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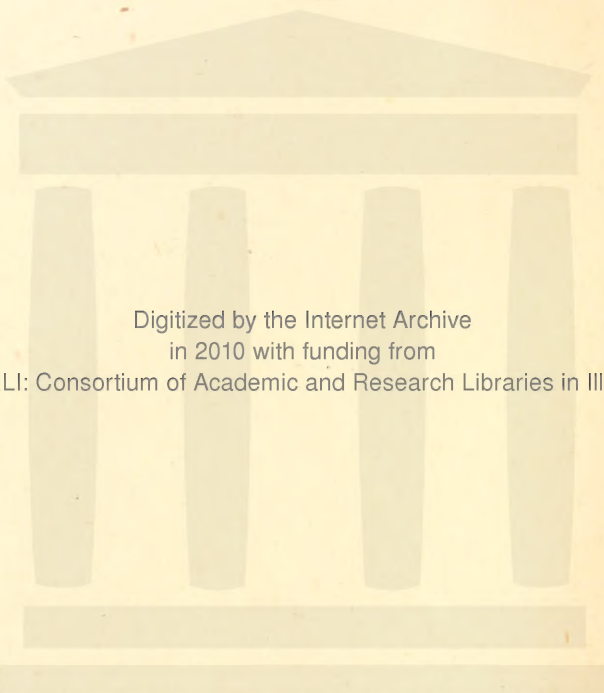
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## ORIGINAL COMMUNICATIONS.

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### NATURAL SELECTION IN IMMUNITY FROM DISEASE.

BY ROMAINE J. CURTISS, M.D., JOLIET, ILL.

It may be said that the germ theory of the origin of disease is accepted by the medical profession, to the extent that there is an attempt to settle all medical problems from this standpoint.

Experimenters and generalizers are now working at the question of what causes immunity from disease, after one attack? The theories, queries, or hypotheses advanced are numerous and ingenious; but, of course, not all of them can be correct. Generalization means that a single antecedent, or cause, must be found for a class or group of phenomena, and the method of finding it is to select a cause that is a true cause in nature, and then test the different or many phenomena, and learn if the true cause is a sufficient cause for all of them. The next step is to show that all other hypotheses are vain guesses, and the next is to verify, if possible, the generalization itself. The hypotheses of gravitation, and the etherial medium of light have been this method of solution.

There are two or more important factors of the immunity from disease which must now be noticed. In the first place, with relation to communities. it is noticed that not all people, who

are exposed to disease, are made sick. Disease infection, or contagion is widely disseminated, or is diffused by epidemic forces, yet a large proportion of people, differing with different diseases, are exempt. The condition of the exposure is such that this cannot explain the exemption there is something else. Looking, now, at the person, we find that different tissues, organs, or cells bear this same relation of immunity, relating to different diseases. In each disease (or nearly) certain tissues or organs are exempt, which confines the *contagium vivum* to certain other tissues or organs, as small-pox is limited principally to the skin.

In this case as in the community case, this exemption has been acquired by some means. We say the germs have an "affinity" for certain tissues, but in organic or social life, affinity, in a particular direction, only means greater resistance in other direction. "Affinity" is the inverted expression for the direction of least resistance.

It is now necessary to find an explanation for the fact of exemption from disease in certain proportions of people in communities, and certain organs and tissues in people; but before naming the hypothesis I will mention another factor of immunity, which is observed by everybody, and which is that persons, tissues, and organs lose their protection, vaccination runs out, and so does every other immunity run out. It is a corollary of this law that immunity is not guaranteed for any definite length of time. It varies in duration, in different diseases, from a very short time to a lifetime. I think as good a general law as can be formulated is that the duration of immunity varies directly to the severity of the disease. This is why small-pox gives greater immunity than varioloid and kine-pox.

There must be found a single law, a true cause in nature, which can explain these diverse phenomena of immunity, as well as all, or any other phenomena, that may be discovered. There can be no science on this subject until this law is found. As a hypothesis I propose the law of natural selection, in relation to variation and atavism, and think this will explain everything that any man knows on the subject of immunity from disease.

I need not explain variation and atavism, further than to say that they are established causes in biology, and account for even the origin of species. The law governing variation is that the

struggle for life, or individual antagonism, causes a differentiation of structure and function. When two organisms fight, or when each struggles with adversity in its environment, the result is that a variation is caused in its structure and abilities. This variation is what allows the "survival of the fittest." But conditions change, and if the cause of antagonism and variation be resumed, the organism reverts again to its former type, which change along the retrograde line, is called atavism. Organic phenomena, relating to life and change, are made up of interchanges between variation and atavism. If an animal acquires speed by being chased by other animals, the acquisition is due to a variation. If the beasts of prey which do the chasing are destroyed, the speed in the other animal is gradually lost. When a fatigued doctor goes a fishing, by rowing about he acquires by variation in the cells of the integument of the palm, which appears as callous. When he resumes his place in the profession as a duly registered physician, he forsakes the oar, and the cells of the integument, by atavism, revert to their former type, and the callous is removed. These are two special instances of variation and atavism: but, now, what is meant by natural selection in this relation? When the prairie wolf chases the antelope it is because the flesh of the antelope is adapted as food to the wolf. This general law is the wretchedest thing on the mundane sphere, and underlies all evil in the world. If the wolf can't destroy a bear or buffalo, and can't catch the birds, and can't find the rabbits, it is because these animals have acquired by immunity and heredity, by a successful resistance, so the wolf chases the antelope, if happily he may catch him. This is called natural selection. Some people like to call it "Affinity," but the wolf selects the antelope for the reason that he can't select anything else. Now, when the wolf makes this natural selection, he pursues the antelope, which, if he has acquired speed by such contests and heredity, escapes, and the wolf dies of starvation: following which the antelope stands around nibbling grass and loses its speed by atavism.

This gives the whole story of natural selection, variation, atavism, and transmission by hereditary descent, and the sequent survival, immunity and atavism.

The point I want to make clear is that a variation is brought

about by actual combat with a personal enemy, or by other environing antagonisms to which the organism must adapt itself by a variation in order to live.

With these general principles we are ready to investigate disease. The first question to ask and answer is, why is there such a thing as disease? The reason is because living things live on each other, because their diet is the same as the material of their structure. The disease microbe is not in the body by accident. It is there because natural selection has determined it and the battle is now between the tissue cell and the microbe. Living things do not consume each other alive. Animals and other living things, kill each other, either mechanically or by poisons, before consumption. The microbe can not consume a living cell with its feeble osmosis, so it poisons the cell by its own physiological product for this purpose. It is then a struggle between virulence of the microbe and physical resistance of the cell, with the results of variation on the part of both, and survival of the fittest. As the struggle and variation continue between cells and their descendants and microbes and their descendants, with variation and its heredity on the part of both, the result depends upon the resources of the combatants in the line of variation.

That cells acquire a "tolerance" to poisons, is known to all, in the use and abuse of alcohol, opium, arsenic, etc. This is proof enough that the cells acquire a resistance to poisons through individual combat with virulent microbes.

Now let us apply the law to the phenomena of disease, and first, what gives rise to pathological products? The new formation in anatomy—the new cells, are the resultants of nature's efforts at repair, and the forces of disease. The force of disease is poison and death of cells; the force of repair comes through the physiological creation of cells by other cells. The pathological cell is a cell that has an extreme variation from the tissue cell. That these things are true, is confirmed by the fact that the definiteness and character of pathological cells corresponds directly with the character of contagion and the tissue that is diseased. Perhaps it is difficult to verify that the variation can be so great in the reproductive power of cells, but the pathological growth is the result of nature to repair injuries, sub-



ject to poisons, and the new growth may be a product of nutritive material, subject to poisons, rather than of tissue cells.

But the variation of cells caused by combat with poisons which enables them to resist poisons, is not, in this sense, a new growth. It is the same as the variation which enables them to resist opium and alcohol. The variation is transmitted by heredity, and there is no escape from the conclusion that it is this acquired variation and its transmission which gives the immunity from disease and also brings about what is known as the law of limitation of disease, both in persons and communities. The disease in a person terminates, not so much from "cure," but because the susceptible cells have acquired by conflict and variation and inheritance, a successful resistance to the poison. In communities a disease terminates because susceptible people have acquired an immunity and transmitted it. Of course there are other factors which relate to the environment of microbes that are not included in this calculation—for instance "sanitation."

The person, by this means, acquires an exemption, for a variable time, to attacks from the same disease, and, as has been proven from attacks of certain other diseases. Experiments of Sternberg and others seem to show that ordinary septic bacteria acting upon a person or animal give increased resistance to disease microbes of many kinds, other than the septic organisms.

Taking up the phenomena of disease, the question comes up why do diseases affect certain tissues or organs? The explanation is in the fact that all other tissues and organs have acquired an immunity. The microbe has an affinity for certain tissues because such is the direction of least resistance. It "selects" the tissue and cells which are least able to resist it. The same law holds good in relation to communities. Certain proportions of the people are not susceptible to a disease infection, and a given disease works only among those who are susceptible. Every feature of these phenomena that I can think of are readily explainable by these laws, or by the law that natural selection or variation gives immunity from disease, and that this variation is transmitted by heredity.

The cessation of the great epidemics of the middle ages—plague, typhus, and sweating sickness may be explained by this law. The public acquired and transmitted a variation, the

character of which enabled a successful resistance to be made to the epidemics.

But there is an obverse side to the problem. On this side we find the fact that immunity does not last. It gradually dies out. We account for all such phenomena by the law of atavism. The cells, no longer being subject to combats with the poison, revert to their primitive type, just as the antelope loses its speed when no longer chased by wolves. This type of atavism is transmitted by heredity, and in time the person or community is again susceptible to disease.

I am confident that this law will explain all phenomena in question relating to disease. It being an established law of biology, its claims cannot be ignored or its influence escaped in the solution of the problem of immunity. But to establish it we must show why other hypotheses are not explanations, which I will defer until a future time, as these hypotheses are rapidly accumulating.

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## UPWARD DISLOCATION OF PATELLA.

BY S. W. DODGE, M. D., REYNOLDS, NEB.

March 4, 1885. John W., Irish, single, age 30, almost a giant in physical make-up, was brought to my office about one hour after the following accident: He was chopping a large limb from a fallen tree that was lying over an embankment. He was aware that when the limb was severed that it would shoot upwards, and he expected to move in time to avoid a collision, but his expectations were not realized, and ere he was aware of it the end of the limb struck him with great force under the knee-cap of the left leg and he was precipitated down the embankment. Friends brought him to me and on examination I found the patella driven upwards nearly four inches with the ligamentum patella completely ruptured from the patella.

No discolorization of the skin, nor was there any at all afterwards. Now as to treatment. I confess I was in a quandary. My works on surgery simply stated that it was an uncommon occurrence and to treat same as for fracture of patella. I finally hit upon this mode of treatment: Elevated the foot to relax the

extensors, manipulated the misplaced bone till I had returned it as nearly as possible to its original position: an assistant held it firmly while I put on a strip of surgeon's rubber plaster about one inch wide and a foot long, the center coming over and above the patella, the ends being carried downward and backward and made fast. I then put on figure of 8 bandage, and a temporary splint till I could get one made for better services.

Patient went home with instructions to keep foot elevated and remain quiet. What was my chagrin the next morning to be summoned in haste to learn that he had attempted to walk across the room to breakfast and had fallen, tearing everything loose and the patella apparently higher than at first. I now had a tin trough made to reach from middle of leg to middle of thigh, which, after again putting on the rubber plaster and figure of 8 bandage, I bandaged firmly to the limb. I reapplied the dressing every two or three days, each time gaining on the patella till now there is only about one-half inch intervening and that is filled with hard callous effusion. In six weeks the splint was removed, patient walking with aid of cane. Now (July 10) scarcely a noticeable limp. No stiffness of joint, and very little weakness. There never was very much swelling nor much pain. He is a farmer and was following the plow within two months after the accident.

## REDUCTION OF AN INVERTED UTERUS.

BY ROMAINE J. CURTISS, M.D., JOLIET, ILL.

Mrs. A., of Irish extraction, was attended in her fifth confinement, when about 30 years old, by a midwife (unfortunately not a "licensed" midwife). The results of the labor, and efforts of the midwife were the birth of a boy and complete inversion of the uterus. After two or three weeks Dr. Casey, of this city, was called to the case, who made a diagnosis. The patient, during this time, was subjected to hemorrhages, and had the usual sequelæ of such a condition of things.

Dr. Casey, after palliating the symptoms of his patient for a few weeks, brought about a better condition of things in general, and reported his case to Dr. Hosmer and myself, by way of

consultation. A council of war was held, and the conclusion was to attempt the restoration of the natural position of the uterus. The accident occurred about two years ago, and the operation for the reduction of the inversion was performed two months after accident. The method adopted was that of the late Dr. James P. White of Buffalo—the writer having been present at several of these operations by Dr. White was acquainted with his method, and its phenomenal success. Dr. White was certainly the professional hero of the operation for replacement of the inverted uterus.

The method consists in compression of the uterus by the hand, for the purpose, at first, of depleting the tissues of blood and other fluids. This effect of depression naturally makes the uterus much less in bulk. After this effect is accomplished, the effort is to invert. The inversion may begin either at the mouth or fundus—depending on which of them has the least resistance to the remedial forces. The force brought to bear for the purpose of inversion is by the use of an instrument devised by Dr. White, which he named his “egg beater,” because it looks like one. It is made of (1) a wooded stem, probably 16 inches long, and should be curved. On one extremity is fashioned a cup, not quite so pronounced as the cup at the end of McIntosh’s universal uterine supporter, while at the other end is (2) a spiral spring, made of steel wire. When in use the cup is applied to the uterus, the spring rests against the chest of the operator, who can thus exert all needed force. While using compression, and the force through the egg beater, counter pressure is used to the uterus through the abdominal walls.

Provided with these tools and methods, we etherized the patient and went to work. One hour was occupied by Dr. Hosmer and myself, alternately relieving each other, in the work of compression. This labor, to a non-laboring man, is paralyzing.

The uterus was larger, nearly filling the pelvis, but in an hour we had it so small that the hand could surround it. The blood escaped in every direction—through the vessels into the circulation, and out of the vessels into the vagina. In about an hour and a half it became apparent, through the medium of tactile sense, that the uterus was turning by way of the mouth



and cervix. We could feel that it was growing smaller and shorter. Our fatigue was great, but we were braced up by the expectation of success. After two and a half hours, as Dr. Hosmer and I relieved each other, the contest appeared to be not only with the uterine condition, but I am constrained to say that the two operators were subject to an unconscious struggle with each other. Each, no doubt, wanted the operation done—wanted it over—but no doubt each, unconsciously to himself, wanted to complete the operation. At the end of nearly three hours, my turn for work came on, after witnessing unusual effort on the part of Dr. Hosmer for nearly half an hour. On inserting my hand I found the uterus rather high in the abdomen, and nearly turned. My first thought was that I would finish that job in five minutes, but feeling around I discovered that an “accident” had occurred—there was a rent in the vaginal wall on the right side large enough to admit three fingers. Further effort was of course out of the question. I drew the uterus down and adjusted the fractures in as good a position as possible.

The woman was placed in bed to recover from the anæsthesia. The treatment for the next two weeks was principally antiseptic vaginal washes, frequently repeated. There were no untoward symptoms except some phlebitis of right thigh. The next morning after the operation, the patient described the sensation of a peculiar movement of the uterus. Being informed of her condition fully, she declared that her sensation indicated the restoration of the uterus to its natural condition—or the completion of the inversion. Subsequent events proved that she must have correct. In a few months her menses returned, and within a year Dr. Hosmer attended her in a premature confinement.

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## MAN: AN ESSAY.

BY W. J. CHENOWETH, M. D., DECATUR, ILL.

Read before the District Medical Society of Central Illinois

I shall trust to the importance of my subject, and not to the introduction of new arguments or of recently discovered facts, to compensate you for the time spent in listening.

Without controversy, man stands at the head of all organisms on earth. Whether this has been brought about by a slow

development from lower organisms, or is the result of an immediate creation, is in dispute. A literal interpretation of the history of man's origin given in the Book of Genesis, has induced the belief that it was immediate. And that is, probably, the prevailing belief at this time, although it is now agreed that a very long time passed from the hour when God said "Let there be light" to the time when He created man. The statement that man was made first, and woman was made from man, is so opposed to the method of *propagating* the species, that it seems irreconcilable with any other theory than that of immediate creation. But the difficulty vanishes if *mankind* is substituted for *man*. While the doctrine of development had a theoretical existence in the earlier centuries of the Christian era, and the view was extended after the conquest of Alexandria by the Arabians, and many writers declared that immediate creation was an impossibility, Draper says, "In the religious revolt against philosophy that took place toward the twelfth century, these ideas were exterminated and never again appeared in Islam. He further says, "If the doctrine of the government of the world by law thus held in detestation by Islam, it was still more bitterly opposed by Christendom." There was no possibility of establishing the theory of evolution without the aid of the physical sciences. The starting point of Christendom, in this theory, was the publication by Copernicus of the book "*De Revolutionibus Orbium Celestium*," in which the Pythagorean view of the em-  
placement of the solar system is revived." These ideas were matured by Kepler, Gallileo and others, and with the steady advance made in the physical sciences the doctrine of evolution has grown apace.

Lamarck, in his "*Philosophic Zoologic*," issued in 1809, advances the doctrine that organic forms originated by spontaneous generation, the simplest coming first, and the more complex being evolved from them. In 1844 an anonymous publication (*Vestiges of the Natural History of Creation*), set forth the view of Lamarck, "and being cleverly and attractively written passed through a great many editions." In the discussion of this book the author made use of a most important anatomical discovery: "That even in the case of the highest species, man himself, the embryo does not simply grow, or increase in size,

but passes in succession through a series of forms which, examined from epoch to epoch, are totally dissimilar." It had heretofore been held that all parts of the animal existing at birth were present at conception, and that the embryo reached birth as the infant reaches maturity.

While opinions were forming and men were confused in reference to the development of organisms, they were assisted in their studies by the gradually accumulating knowledge of geology. As early as 1680 Leibnitz had proposed that the earth had once been in a molten state, from heat, and that the primary rocks were formed by the cooling of its surface: and in 1756 Lehman had grouped the earth's strata in chronological order. But to Lyell is due the credit of having taught, in 1830, in his "*Principles of Geology*," the gradual development of the earth. And from that time it began to be believed that the six days spoken of in Genesis, in which the earth was created, were six periods of time, each of which was many thousands of years duration; and it is not now a matter of opinion, but of demonstration, that the lowest forms of life, vegetable and animal, commenced in the first period, and that they were more complicated and more highly organized from period to period.

In 1859 Darwin published his work on the origin of species, in which he seeks to prove that organisms have a tendency to develop in the likeness of their progenitors. But variations are continually produced. "No chick and no child is in all respects and particulars the counterpart of its brother or sister," and that variety which is best adapted to its surroundings will multiply more rapidly and be more vigorous than others: that a struggle for existence has been going on through all of the ages, the few and the weak giving way before the more numerous and the strong, or to those organisms which have been more perfectly adapted to their environment: if a sufficiently long time be given a slight change may result in a vast modification.

Controversy succeeding the publication of this book became very bitter. Advocating the views announced was regarded as an advocacy of infidelity, and ostracism from Christian fellowship was not an infrequent result. But investigation is now permitted and what of truth is in it will stand.

In 1871 Mr. Darwin published a work on "*The Descent of*

Man," in which he adduces proof tending to show that man's ancestors were a line of inferior animals, or to quote his words. "Man is descended from some less highly-organized form," and "still bears in his bodily frame the indellible stamp of his lowly origin: or, as paraphrased by Balfour, "Each organism reproduces the variations inherited from all of its ancestors at successive stages of its individual ontogeny which correspond with those at which the variations occurred in its ancestors." So that man's embryonic existence "is a recapitulation of his genealogy during the enormous duration of terrestrial life." If this is not so, "these progressive stages are not only inexplicable, but are so deceptive as to suggest the explanation once current as to fossils—they are 'delusions of the devil.'"—(S. E. Chaille.)

Embryo life ceases as soon as the embryo is capable of living in the element for which it is destined. So soon as the fish acquires gills, and an alimentary canal, so that life can be maintained, the vitelline circulation, which had supplied air, water, and food ceases. If the environment in which it is to live require an additional supply that embryo life may be prolonged, a new and most perfect means is instituted. With birds, the vitelline circulation having ceased, the organism is continued in its embryo state by the allantois, which maintains the supply of food, air, and water until the bird is able to live outside of the shell.

In like manner mammals are dependent, first, on the vitellus, or yolk, then on the allantois, but these ceasing, and the embryo being destined for a higher organization, the placental circulation is established, the embryo passing through all of the stages incident to fishes, reptiles and birds before it reaches the placental stage.

Tracing the development of a mammal, for instance, of the dog, sheep, horse, or man, all of them originate from the coalescence of two cells, the ovum and the spermatozoon, this product undergoes a process known as segmentation, in the course of which it becomes divided, in typical cases, in a number of cells which constitute the material from which the body of the young animal is developed. A variety may occur at some stage of growth which is inherited by the issue of the organism, and there is, afterwards, a divergance which increases until what commence life as one specie becomes many. A hog does not change



into a cow, nor does a horse change to a dog, nor a monkey into a man, but at some remote period the ancestors of all of them were the same. Darwin has been grossly misrepresented, in alluding to his views on this subject, that I call attention to the following, copied from the descent of man:

“The quadrumanna and all the higher mammals, are probably derived from an ancient marsupial animal, and this through a long line of diversified forms, either from some reptile-like or some amphibian-like creature, and this again from some fish-like animal. In the dim obscurity of the past we can see that the early progenitor of all the vertebrata must have been an aquatic animal, provided with branchiæ, with the two sexes united in the same individual, and with the most important organs of the body (such as the brain and heart) imperfectly developed. This animal seems to have been more like the larvæ of our existing marine ascidians than any other known form.”

If it is true that man passes from an egg to birth through the same slow and gradually progressive modifications, depends on the same contrivances for protection and nutrition, and finally enters the world by the help of the same mechanism, wherein does he differ from other mammals?

It is a law that embryos, at any stage of their existence, until prepared to live in the element for which they are being fitted, may grow without being developed, or develop without growing. A giant develops with an abnormal growth. A dwarf does not grow naturally, but development may be perfect. It is also true that any part of an organism may fail to be developed and continue to grow, or cease to grow and continue to develop, affording proof of the lowly origin of man. If, in the human embryo, development does not ensue at conception, there may be growth and multiplication of cells, as occurs in hydatids of the uterus. At the third week the embryo is, in appearance, a jelly-like worm, which, growing without development, may be thrown off as a false conception. At six weeks it has the gill apparatus of the fish, the gill fringes not being required, are atrophied. But the branchial arteries which form the permanent arteries of the fish are transformed into the arterial system



of man. Branchial fissures are sometimes found in the neck of adult human beings.

In fishes there are two little sacks which open into the upper part of the alimentary canal and which constitute their lungs. This condition is found in the human embryo. The heart of the embryo of man is first a small pulsating sack with a single chamber, such as is found in the lancelet, one of the lowest organizations, a link between worms and vertebrates. Afterwards it is divided into two parts, as in fishes. After this into three chambers, as in reptiles. And it does not become four chambered until about one week after birth.

Paget cites a case of a heart, preserved in the Pathological Museum, which had but a single cavity, but which was of more than the average size of children of the same age. He also refers to another where the septum of the ventricles was incompletely formed: this patient lived for eleven years. Cyanosis, or blue disease, is caused by want of closure of the septum between the auricles, a condition which leaves the heart three chambered. The kidneys of man are at first wolffian bodies, the same as the permanent kidneys of the fish and the frog. The human embryo has, until twelve weeks, a common fœcal and genito-ural outlet as fishes, reptiles, and birds have permanently.

At eight weeks the embryo man has a tail which projects beyond his legs as far as does a dog's tail at the same age. The muscles which formerly moved the tail are still present in adult man, but are atrophied for want of use. It is possible for the tail to grow.

April 28, 1878, Mr. Owen related to the Harveian Society of London the case of a fœtus which he saw, which had a tail which was curled up on one buttock and distinctively moved. It was removed successfully, by ligature, and is now in the museum of Guy's Hospital. The child lived to be sixteen years of age.

We might call attention to the bones, the skin, the uterus, the vermiform appendix, and other parts of the body, as showing evidence of evolution in man, and to rudimentary organs found in other organisms—as teeth in whales, snakes with feet which by disuse are atrophied and hidden: insects with wings

which are immovable, showing the common origin and mode of development of man and the lower animals.

But we pass these by to call attention to the nervous system of man. The brain of the human embryo at about the sixth week consists of two lobes or vesicles. And subsequently the posterior of these again becomes divided into two, so that three lobes are formed. Of these the hindmost is usually the longest. The brain is now like that of the fish, "in the small cerebrum, in the absence of convolutions, and deficiency of commissures." At the twelfth week it resembles the brain of a bird, the cerebral hemispheres being rudiments of the anterior lobes. During the fourth and early part of the fifth month, the middle lobes develop backwards, covering the corpora quadrigemina, extending subsequently so as to cover the cerebellum. If development is arrested at this stage, the child will be born with a brain corresponding to the time of arrest; if before the sixth week it will be without a brain, if later it will be idiotic.

The hemispheres of the brain enlarge as we ascend in the animal kingdom, and the gray surface is further increased by being thrown into folds, and in any two animals of equal size and like structure, the one whose convolutions are more numerous and complicated, and the sulci deeper, will be the more intelligent, the superficies of the gray matter determining the mental capacity. Nervous matter manifests its presence in the lower organisms by what is known as reflex action. In the higher birds and mammals, similar, but a greater amount, manifests mental functions. Reflex action causes the heart to pulsate, the lungs to inhale air, the liver to secrete bile, the stomach to digest, and enables the animal to procure food and avoid danger. The simplest form of reflex action may be represented by the passage of a nerve fiber to a cell, conveying an impression, and the passage of a second nerve fiber from the cell communicating the receipt of the intelligence. As organizations become more complete, reflex action becomes more complicated, and it becomes impossible to tell where reflex action ends and mental function begins.

A case frequently cited will illustrate this. Pfluger decapitated a frog, and then placed some acetic acid on the animal's thigh. This headless creature immediately wiped off the acid with the bottom of the foot of the same side. Pfluger then re-

moved this foot and again placed the acid on the same thigh. The animal at first, as though deceived, endeavored to rub away the acid in the same way as before. This being impossible, the frog soon ceased trying that method, and seemed to be seeking some other plan. Finally, he made use of the foot which was left and actually succeeded in removing the acid. The muscles in this case seem to have been used intelligently, in obedience to will, although the frog did not have a brain. We therefore conclude that the act was reflex, or that the spinal cord thinks and wills.

Another case will still further show the difficulty surrounding this subject: Dr. William Darling, Professor of Anatomy in the University Medical College of New York, nine hours before his death, when in a condition of delirium, delivered a complete lecture on anatomy, which was perfectly coherent. Ordinarily we look upon a feat of this kind as a mental act of high order, but as Professor Darling had neither consciousness nor will, we may class this as a reflex action. In the case of the frog there was reflex action evincing mental function: in the case of the teacher there was recognized mental action of an exalted character, simulating reflex action.

We have but limited knowledge of nerve function and if, after careful study and patient research, we forever fail to understand its mysteries, we may console ourselves by the reflection that we will also probably remain in perpetual ignorance of the cause of heat, electricity, and chemical action, which result from certain molecular movements.

A habit, however slowly and painfully acquired, becomes, by frequent repetition, automatic, the higher nervous centres not recognizing the act. It is with difficulty and slowly that we learn the letters of the alphabet, then words, syllables, and sentences. But once having learned to read, we do not, consciously, separate words into syllables or letters. The skilled musician may engage in conversation while performing a piece of often practiced music. The duck will swim as soon as it is out of the shell, and the quail will hide at the first sight of man. These acts are inherited, having been repeated by their ancestors from generation to generation, with little or no variation, from birth to

death ; the tendency to perform them is completely organized in the nervous system before birth.

The frequent repetition of music by the musician has qualified his nervous system to act automatically. Just as frequent repetition in the ancestors of the quail, or duck, have qualified their nervous system. This will be more convincing if we will recall the fact that children born of parents whose lives have been passed in the performance of any special acts, requiring either physical or mental training, can not only learn to perform these acts more readily than other children, but in some instances will repeat them without instruction. In inherited acts there is performance without consciousness. In acquired acts there is a conscious attempt before performance ; and yet acquired acts by frequent repetition become as clearly automatic as are those which are inherited.

While we may never be able to tell how nervous matter generates consciousness, thought, memory, or will, it is reasonable to infer that if stimulation of an afferent nerve will produce reflex action when connected with one of the lower nervous centres, it will excite mental action when connected with the cerebrum—the recognized seat of the mind. If an impression is made on the sense of touch of one of the lowest organisms of the animal kingdom, reflex action immediately follows, resulting in an attempt to avoid further contact with the offending object. And if an impression is made on the eye, the ear, or on some other organ of sense in man, it is conveyed to the gray matter of the cerebrum and excites it, producing an idea. There is a sensation resulting in agitation of the mind which we call emotion. This is in some way registered or retained, and thus produces memory. And will, the most characteristic mental act, is the response given to the impression. Just as motion was the response given by the lowly organized creature to touch.

What are the legitimate results of possessing a larger brain and greater mental capacity ? This may be determined by a very rapid review of the past. The first "Lords of creation, huge flying reptiles," were followed by successive dynasties of mammals, all of them long ago entombed in the strata of earth which records the period of their existence. Sight, hearing, smell, fleetness, agility, or muscular power, enabled them to save



their own lives or to take the lives of their competitors. During the countless ages when life was lost or was preserved by these means, a time came when some mental superiority gave our brute ancestors an advantage over the physical power of their enemies. And that part of the brain on which this mental superiority depended grew as the demand for its use increased, until finally the struggle for supremacy depended almost exclusively on mental superiority. And the result is now manifest, man is, and by this token, he ever will remain at the head of the animal kingdom.

He has subjected to his will and made subservient to his purpose, many of the inferior animals ; has taught them to carry burdens, draw vehicles, and to guard property. He has domesticated some of them to give him food, others to afford clothing. He has selected from the vegetable kingdom herbs and fruits for his table, and flowers for odor and beauty. Minerals serve him for mechanical and for commercial purposes. Having made visible things subservient to his wishes, he is now laying his hands on the molecular and chemical forces, and as time advances his power increases, and, judging from the past, it must continue to grow. Other animals may increase in intellect, and even learn to talk ; but at the vast distance at which man has left them, it will take them an incredibly long time to reach the height which he now occupies, even if taught by him. But man "has the promise and the potency" of still greater knowledge and excellence. Every age marks the grave of some superstition or error, and the presence of some truth which has sprung up in its place. Each succeeding generation is more liberal and better informed than the preceding. We may therefore reasonably infer that man will retain his supremacy until some cataclysm buries him, with all other creatures, beneath its indiscriminate waves.

But if a man die will he live again?

That man may be resurrected, it has been deemed a necessity that he shall be possessed of an "immaterial supernatural element." The argument, if such it can be called, which is used to substantiate the claim, is like the claim itself, very beautiful but very flimsy. Dr. Parvin, in his inaugural address before the American Medical Association in 1879, says: "Let this body be



blown about by the winds, or sealed within the iron hills, it does not follow that the love and the hope, the aspiration and the desire, the knowledge, the will, the reason and the conscience—those spiritual elements which defy weights and measures, chemical analysis, and the most powerful objectives—should perish.” This is very pretty, but it does not give reasonable hope for a future existence. God, or the knowledge, or by whatever title we may designate the great architect of the universe, has always worked out His plans in accordance with fixed and unalterable laws, and although we have the power, the more we study into his wonderful designs, the less we are inclined to believe that anything has, or ever will occur, without strict compliance with established law. If there is, therefore, a renewal of life after death it will be in accordance with law. We cannot, therefore, reasonably suppose that we can exist in the future in a manner totally different from the present life.

Now we have a tangible, material, substantial body. To exchange this for a shadowy apparition, is unnatural and contradictory. We need not put our faith on the stretch by resorting to the untenable and visionary theory that life, as the cause of the organism, existed before it, and may therefore exist after it. “Perception, intellect, motion and will” are recognized attributes of mind. They are also supposed to designate the characteristics of the soul; but if we accept this definition it is not possible to believe that all persons have souls, for all do not have minds. There are many human beings who have less capacity to reason than dumb brutes, who are not supposed to have souls. If the soul is the mind, it is feeble at some periods of life, and strong at others. In infancy it is feeble as the semi-fluid brain it is credited with producing. In adult life it is as strong as the brain and body will permit. But when life begins to wane, it is no longer buoyant and elastic, and in the decrepitude of old age it becomes as feeble as in infancy. And further, if a man as wise as Solomon, or Bacon, should have his skull crushed or the bloodvessels of his brain torn, his soul might be reduced to that of an idiot; and if the depressed bone should be elevated, or the extravasated blood should be removed, the soul would then be in a condition to regain its lost powers, unless the structure had been changed, necessitating the change of function. The soul, if it is

mind, depends on the quality of blood furnished to the brain. A bloodless brain has no soul. A brain supplied with poisoned blood is itself poisoned, and to add to the difficulty of believing that the soul and mind are the same, a child depends on its parents for the quality of its mind, while the advocates of the soul claims that it depend directly on God and existed before the germ which prefigured the body was created and itself gave it life and form.

Drunken parents beget idiotic, epileptic, or insane children, and wicked parents beget wicked children. In 1877 Dr. Dugdale made a report to the New York Prison Association, in which he traced the progeny of a thief and harlot to the sixth generation, and histories of 109 out of 1,200 descendants were obtained. More than one-third of them had been recipients of public charity, more than ten per cent, had been punished for crime, a large proportion had been diseased, and nearly all had offended against virtue. These "jukes" had coarse and brutal minds, their delinquencies having resulted from inheritance and not from the instigation of the devil.

The soul must, therefore, of necessity depend on the body for its qualities and its very existence, and separation here or hereafter means annihilation.

As we have already seen, mental function is the direct result of impressions conveyed to the supreme nervous centers from one or more of the senses, and if a resurrection occurs, that part of man which lifts him above other animals must be renewed. Balfour states the law in this way: "Reproduction essentially consists in the separation of a portion of an organism which has the capacity of developing into a form similar to that which gave it origin." Independent of revelation, there is absolutely no hope of a life hereafter unless the body be resurrected in accordance with the law of reproduction. The scientific idea of a resurrection is formulated in the adage "*omne vivum e cellulis*." Every living thing has sprung from a cell. The Great Teacher has expressed the idea in this language: "Whatsoever we plant that shall we also reap;" "Do men gather grapes from thorns, or figs from thistles?"

To me it is a pleasure to reconcile the teaching of science with the declarations of the Scriptures. Wherever in the New

Testament mention is made of a future life it is as a place. It is called a house, a mansion, a city, a country, and the resurrected are said to have bodies. St. Paul dwells on this as a fundamental doctrine. He says: "Christ was raised from the dead, the first fruits of them that slept." "For if Christ be not raised from the dead we are of all men the most miserable." "If the dead be not raised neither hath Christ been raised." But more emphatically still: "With what manner do they come?" He replies to his own question, "If you plant a seed of wheat or other grain it is not quickened except it die."

We are thus assured that if this body dies another will spring from the remains. It will be changed to meet the surroundings, but will be a body. The cell from which it will spring has not been seen, or if seen has not been identified. Nor is this surprising, as in all probability it is a mere microscopic speck, surrounded by myriads of other cells more or less like it. From analogy we may infer that it is indestructible. It has been demonstrated by Mr. Dallinger and Dr. Drysdale that the spores of one variety of septic monads, which are so minute that they cannot be seen except in mass by the highest powers of the microscope, are capable of germinating after being subjected to a heat of 300 deg. F. for ten minutes. If, therefore, the received opinion that the earth will finally be destroyed by fire is correct, there is no reason why cells may not be found in the human body which are indestructible by heat. Doubtless cells existed when the world was a molten mass, and they may survive a burning world. The length of time which must elapse before a resurrection can be effected is not a bar to its occurrence. A germ may lie dormant for an indefinite period, and if placed in suitable soil will fructify. A grain of wheat has lain with the body of a mummy for three thousand years, and has grown when placed in the ground. The germ now hidden in our bodies may lie dormant for countless ages, in the grave, or in the ocean, or while driven about by the winds, and finally be evolved from the womb of time in a manner different from, but not more wonderful, than that by which the present race of mankind have descended from a simple piece of protoplasm, or from the dust of the earth. "Throughout the whole series of living beings, we find Agomogenesis, not sexual generation." And Christ himself says, "In

the resurrection they neither marry nor are given in marriage."

So we are warranted in advocating a resurrection of the body by the teachings of science and the declarations of Holy Writ.

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## INTRA-UTERINE HYDROCEPHALUS.

BY C. BARLOW, EATON, ILL.

Last Friday evening (July 10) I was called to see Mrs. A. B. Primipara, who had been in labor for a short time. She stated that the membrane had ruptured at the beginning of labor, and that her pains had not been severe. On examination the child was found to be very high up, and the os dilated so that I could readily introduce the index finger. This examination was not satisfactory. I was unable to make out the exact position of the child, but thought it to be a head presentation, left occiput to anterior position. During the night her pains were truly severe at times. The os was now dilated so that two fingers could be introduced readily enough, but the presenting part was high up as before. I could discover what I supposed to be the anterior fontanelle, but it was too large, in fact I could feel nothing but fontanelle as far as I could reach. I administered a dose of hydrate of chloral and morphine, returned to my office until afternoon, when an examination revealed much the same condition, except the os was dilated so that three fingers could be introduced, but the exact condition of things could not be ascertained.

The differential diagnosis was now to be made between a hydrocephalic head and a shoulder presentation. It was barely possible that the presenting part was the posterior border of the right scapula instead of the head. This was favored by two conditions. First, there was a great lateral obliquity of the womb to the left side, and a hard tumor in the right iliac fossa which would answer for a head, and was entirely too high up for the head to extend, provided the occiput was the presenting part.

The fundus was too high up for a shoulder presentation, and the soft portion of the presenting part was very yielding and fluctuation could be perceived through it. The integument covering the parts felt more like that of the scalp than the body. If



it was a shoulder presentation the back of child occupied the left dorso-posterior position, while the head was in the right iliac fossa. But if this was the position it would seem that the spinous process of the vertebral column and the ribs could be felt; but nothing of this kind could be discovered, but this might be prevented by tumefaction and the high position of the child.

Thus undecided I called Dr. A. G. Meserve, and we completed the diagnosis under chloroform. We found the head presenting in the left occipito anterior position. We also discovered that the head was full of water, that the edges of the parietal bones were separated about three inches, and that the forehead and face occupied the right iliac fossa. Dr. Meserve performed craniotomy, after which we gave quinine for its oxytoxic effect, and waited for nature to complete the delivery. But the os was very rigid and dilated slowly. We resorted to artificial dilatation with the fingers. We also applied ext. belladonna to the os and gave hydrate of chloral in fifteen grain doses.

After about four hours the os dilated sufficiently to pass over the head. There was some resistance at the perineum which I readily overcame by using the craniotomy forceps. It may seem a little strange that a head presentation could be confounded with a shoulder, but when we consider the extent of the hydrocephalus, the very high position of the child, the great lateral obliquity of the uterus, with only the edge of one of the cranial bones presenting, and the extremely high position of the child in the iliac fossa, we can readily understand the difficulties in the way of making a satisfactory diagnosis.

Playfair says that "nothing short of a careful examination under anæsthesia, the whole hand being passed into the vagina so as to explore the presenting part thoroughly, will enable us to be quite sure of this complication." He also states that "under these circumstances such an examination is not only justified but imperative."

After delivery we gave quinine every six hours, bathed the breasts frequently with belladonna and camphor liniment, and cleaned the vagina every eight hours with carbolyzed water. Patient is recovering rapidly.

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## CORRESPONDENCE.

## NEW YORK LETTER—COLLEGES AND THINGS IN GENERAL.

NEW YORK, April 15, 1885.

DEAR DOCTOR: Almost every medical college commencement which one picks up bears on the title-page the representation of an elegant, commodious and massive structure, supposed to be the theatre of of operation for the great men whose cognomens and accompanying titles are grouped together on the inside pages of the aforementioned pamphlet. The pictures, of course, are very attractive and suggestive. Quite as much so as the long array of names above referred to. Their designers meant them to be so. A magnificent building, standing out in bold relief, towering in a majesty of loftiness above all other objects is the rule. To look at it is to be impressed with its greatness and the eternal justice of its claims upon the patronage of a long suffering profession. Its appearance of silent grandeur calls a halt even from the most superficial observer, and to the thoughtful one, unacquainted with the facts, speaks volumes for the actual worth of the original and the devotion of its controlling spirits.

Such an one, in his imagination sees an interior pregnant with inspiration. Grand old halls are filled with the habiliments of the science and art of physic. An air of mysterious and awful wisdom seems to pervade the very atmosphere—the result of the accumulated experience of ages—and by some inexplicable and irresistible process of endosmosis find its way into the very fibre of the being of every student who has the devotion to place himself within its classic walls. A hushed stillness, amidst the comforts and conveniences of modern life, woo to thoughtfulness. Dignified professors, imbued with the spirit and wisdom of Æsculapius, shed their benign influence upon the assembled devotees at the shrine of medicine, and true medical art, in all her purity of thought and action, finds herself and her children beneath this selfsame roof.

Yes, those pictures are very suggestive. They are meant to be. But to one person they suggest one thing, and to another

person another thing. They are a sham and a deceit. In nine cases out of ten, as every man who has had an opportunity knows, the architectural design is a gross exaggeration of the original, and as to the interior, Oh my! The same conditions which existed twenty years ago, exist to-day. Almost every medical man can remember how disappointed he was when he first set foot inside the doors of his *alma mater*. Her appearance did not compare in beauty with what his youthful fancy had pictured, and instead of that air of philosophical profundity which he had anticipated, he encountered the shouts and hilarious demeanor of his assembled comrades. Bare floors, bare seats, bare walls alone greeted his eyes. Nothing, absolutely nothing, to break the eternal monotony of bareness and make him feel sufficiently at home to remain throughout the term. He found that he could do very much as he pleased, in so far as either study or deportment was concerned, if he only paid the necessary fee and secured his tickets. He selcom saw any of his instructors except during their lecture hour, and never had an opportunity to ask them any question. They said what they had to say, apparently under protest, and went their way to be seen no more until the necessities of the curriculum called them again into the arena.

So it was in the West fifteen to twenty years ago, and so it is in the great city of New York to-day.

The medical college buildings are of average appearance; certainly nothing more. And as for the internal arrangements: why, there is the same old stereotyped appearance which has greeted the eye of every medical student from the time when the memory of living man runneth not to the contrary. There is the same bare, uninspiring and uninviting aspect. The more to be deplored in view of the evident tendency of the medical student of to-day to discard and discountenance the rudeness and boisterousness which characterized the youthful seeker of medical wisdom years ago.

With the exception of the post graduate school, the same apparently insurmountable obstacle to communication between pupil and instructor exists now as existed years ago. There is almost no means of gaining information on any subject, from a professor, except what is included in the text of his regular discourse. He seems just as anxious to get away now as he ever

did, and only too gladly avails himself of the seemingly underground retreat provided for the rapid escape of the professors of every well-regulated medical college. The aim seems to be to give as little instruction for the money as possible, or as is consistent with a due regard for the professor's reputation.

When I have been from time to time impressed with the truth of what I have thus briefly referred to, I have felt impelled to exclaim in the language of the Apostle, "Brethren, these things ought not to be."

No wonder that dissatisfaction exists with the present system of medical education. Why can it not be rendered possible for an individual to secure a medical education amid the surroundings of personal comfort, and decorations and appliances suggestive of professional thought and feelings? Give us a school in which scientific refinement is made an essential to admission. A school in which is cultivated a habit of interchange of thought as between teacher and pupil: where "physician" and "boor" are not considered synonymous terms: where some attention is paid to the cultivation of the amenities and humanities, or at least to the fostering of them, and we will behold an institution worthy of the name and of the age, and one worthy of the patronage and encouragement of an enlightened profession. And not until then.

It was undoubtedly in a feeling akin to the one which now inspires my pen, that the idea of the present post graduate schools originated. Men who had had some experience in actual practice, and knew what they wanted to have an opportunity of studying, felt that attendance on the regular college courses was time and money thrown away. They had no opportunity for investigation. They found themselves in much the same predicament as a prisoner at the bar—possessing the privilege of listening, but not of talking back. Their wants were realized by some of their brethren in a position to help them, and the result has been the establishment of several schools of the kind, the most prominent being in this city. Much of the patronage formerly given the regular schools has thus been withdrawn, and the latter have been practically relegated to the position of primary schools, as it were, in view of the fact that all those who can, finish up in the post graduate schools, where opportunity is

given for personal clinical investigation, and conversation with those who occupy the position of instructor.

But I have already exhausted my time and must close for the *nonce*. Suffice it to say that this subject of medical education is not yet settled, by any manner of means, and if I am not greatly mistaken a great change therein will be inaugurated ere long.

Very truly,

O. B. WILL, M.D.

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## THE MORPHOLOGY OF THE COMMA BACILLUS.

*Editor Peoria Medical Monthly:*

In the June number of your journal you quote William Alexander, M.D., F. R. C. S., as saying "An obscure practitioner who believes he has made a discovery, must keep writing and speaking about it until he gets a hearing, else the discovery will sink into oblivion to be revived again by some one with the apostolic powers that the originator lacked."

Last January I wrote you on the above subject stating that it was the progeny of the comma bacillus that was the immediate source of the infection of Asiatic cholera. I expect you considered the theory so imaginative that you did not publish it; but I acted according to Dr. Alexander's advice and wrote in March to the *Western Medical Reporter*, and the *New York Medical Journal* the same theory and they did not publish it. Since writing on the subject Dr. Jayne Ferran Cluna, of Tolosa, Spain, is seemingly on the verge of demonstrating what I first suggested, viz: that the progeny of the comma bacillus is the source of the infection of Asiatic cholera. The *Western Medical Reporter* has become a convert to my theory as far as I have above reported it, for in an editorial in the July number he says: "The fact that the finest spirillæ are those directly derived from the muriform bodies or its subsequent generation, which similarly occurs with the seed from the dejecta, leads us to believe that the primitive agent of infection of cholera in man is not the little muriform ovuli proceeding from the periplasm which are enveloped in a coat sufficiently thick and resistant to protect them from the above named editorial, that Dr. Farran and many of his followers believed that it was from the annoyance of the stomach and bowels that caused the phenomena of the disease.



I will admit that in part they may; but now as my original theory is getting foothold among great authorities and their followers. I will again send it to you that all the great authorities on cholera may direct their microscopes in the direction I suggest, as follows: The comma bacillus is the mature cholera germ and they give rise to a progeny which if inspired in the lungs of the susceptible are taken into the circulation and fasten upon the blood, and thus by their annoyance through the medium of the nervous system they cause vomitting and purging as a provision of nature to eliminate them; and in this way many of them do reach the inside of the stomach and bowels and dejecta, and perhaps vomit, and also the drawn blood of the patient when in the algid stage, they become rapidly developed into the comma bacilli to again resume their reproduction and cycle of metamorphoses, through how many stages I know not.

I will not make this article further tedious by giving my treatment, founded on the foregoing theories.

SILAS HUBBARD, M.D., *Hudson, Ill.*

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## PERISCOPE AND ABSTRACT.

### OBSERVATIONS ON NIGHT-COUGH, ESPECIALLY IN YOUNG CHILDREN.

Most children who are troubled with this affection show no illness during the day. The following propositions are submitted with respect to affections of this character: 1. Many coughs are not dependent upon any inflammatory or catarrhal process in the larynx or bronchi. 2. They are not generally dependent upon prior enlargement of the tonsil or pharyngitis. 3. They are dependent solely upon a nasal catarrhal inflammation with its accompanying secretion. Mackenzie has shown that certain areas of the nasal chambers quickly respond to irritants or stimulants, and that an explosive act, like a cough, will quickly follow mechanical irritation to the posterior portions of the tubinated bones and the septum. The author has found that the anterior portion of the nose and septum are also extremely sensitive to irritation. The cough at night is caused by the accumulation of secretions in the nasal passages, some of which passes down the pharynx and touches the epiglottis, or escaping the epiglottis, lodges upon the arytenoid portion of the larynx. Cleansing the nasal chambers and removing the mucus will at once arrest the cough.—*Med. News.*



## THERAPEUTIC SIGNIFICANCE OF THE CERVICAL FOLLICLES.

Dr. Simon Boruch in an interesting article (*New York Medical Journal*) on the Therapeutic Significance of the Cervical Follicles, summarizes as follows :

1. A thorough knowledge of the anatomy, physiology, and pathology of the cervical follicles will simplify the treatment of many uterine affections.

2. The cervix uteri represents a large gland of active and important function in the various sexual relations of woman.

3. In the majority of the more common diseases of the uterus the mucous membrane and its follicles play the most important role. A recognition of this fact will make treatment more successful.

4. Metritis, subinvolution, hyperplasia with catarrh, erosions, etc., must be studied in connection with the glands of the cervix.

5. In obstinate cases medicinal applications fail because the secreting surfaces of the follicles are not reached. Scarification and the curette are valuable adjuncts in nulliparous women or in parous women without cervix laceration.

6. In parous women with lacerations, trachelorrhaphy is the most valuable procedure. As a simple plastic operation it will fail. Success depends on extirpation of the follicles, which is more important than "removal of the cicatricial plug."

7. The microscope demonstrates the dependence of catarrh, ulceration, erosion, and hypertrophy of the cervix, and often also of the body of the uterus, upon the glandular structure of the cervix uteri.

8. The cervical follicles are significant as elements in the pathology of cervix cancer, because the microscope demonstrates the dependence of the latter upon erosions, which are based upon the gland structure.

9. Laceration and erosion must be regarded with suspicion, as possible sources of future malignant disease. In operating for their removal, extirpation of the cervical follicles must be unsparing.—*Louisville Med. News*.

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MILK DIET IN THE ALBUMINURIA OF PREGNANCY.

Tarnier's treatment of the albuminuria of pregnancy by an exclusive milk diet has counted in his hands, as well as in those of others, many successes, and it has received a very strong endorsement from Carpentier, among recent obstetric writers.

Under this treatment it is usual to see the albumen lessen, in some cases disappear, and the symptoms which threaten eclampsia, such as headache, dimness of vision, indisposition to exertion, and drowsiness, cease, or become much mitigated. In some cases, however, it is important to conjoin with milk diet a hot bath once in three or four days. The temperature of the bath should be from 98 to 100, and while in the bath or immediately after it, the patient should drink a tumbler of hot milk. A profuse perspiration usually follows, and the relief is prompt and positive. In one case, however, now under observation, a primigravida now in the eighth month, who has had albuminuria for at least four months, and who derives marked benefit from the hot bath, has also a very serious discomfort following it. There is unusual and violent activity of the fœtus always occurring after the bath, so that she is for some hours unable to sleep—a very serious inconvenience, as the usual and most favorable time for the bath is just before retiring.

Valuable as most practitioners regard the milk treatment of the albuminuria of pregnancy, some entirely reject it. Pajot, for example, in a recent discussion held at the Paris Obstetrical and Gynecological Society, and reported in the *Journal d'Accouchements*, May 5th, refers to it as a bitter pleasantry. One of his arguments against the milk treatment is that infants from six months to the end of the first year, are peculiarly liable to eclampsia, and yet they are then on milk diet. Gueniot very well answered this argument by saying that these infants that have eclampsia are not albuminuric, and the milk diet in albuminuric pregnant women does not act upon the eclampsia, but upon the albuminuria: it is only indirectly by curing the albuminuria that it renders eclampsia much rarer. It is impossible to attribute infantile and puerperal eclampsia to the same cause.—*Med. News.*

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## TREATMENT OF SYNOVITIS.

Dr. F. C. Martin, son of the late Dr. Henry A. Martin, who introduced the use of the pure rubber elastic bandage to the profession, gives the results of his father's experience in the *New York Medical Record* as follows:

1. In the last twelve years over two hundred cases of synovitis of the knee, and its sequelæ, have been treated by aspiration with a single strapping of the joint, and subsequent use of the bandage.

2. In these cases the knee joint has been punctured over four hundred times.

3. In all these cases, with the exception of a very few, and these only in the early stages of treatment, the patient was not only permitted, but obliged, to take a daily and considerable amount of walking exercise.

4. In no single instance has there been failure of absolute and entire cure, requiring, in one case, seventeen weeks, but in no other more than eleven weeks.

5. Although no antiseptic measure, beyond perfect cleanliness of the aspirating needle, was employed, in not one instance has any ill symptoms followed the operation. When the needle is withdrawn, the puncture is at once covered securely with adhesive plaster.

Sir Benjamin Brodie long ago declared most emphatically, that when the synovial sac is distended with fluid, it can be punctured, and the effusion drawn off with perfect safety. He does not by any means regard this as a help in any treatment, however, as he says the fluid will accumulate again, and in a few hours the joint will be as much distended as before. The originality and value of my father's method of treatment lies in successfully demonstrating the fact that thorough aspiration of the knee joint, followed by proper use of the rubber bandage, gives us a complete and satisfactory method of cure in even the worst cases of synovitis. By the firm and equable pressure of the rubber bandage, the re-accumulation of diminished quantity, and a second, or perhaps in severe cases a third aspiration of the joint is all that is required. One great advantage of it is to explode the idea that perfect rest of the joint is the only way to hope for a cure. The patient is emphatically *not* to be confined to bed, or, worse still, to a fixed splint. When the joint is strengthened by a properly applied rubber bandage, exercise is a great and important adjunct in the treatment. This very day I have visited a lady who passed last summer in Switzerland. While there, she was attacked with acute synovitis of the left knee, with large amount of effusion into the sac. She was kept in bed, with the limb placed on a fixed splint and continuously poulticed. After sweltering through the hot weather with the limb swathed in many thicknesses of cotton wadding, at the expiration of two months the splint was removed, and—she has come home with a joint almost immovable! I am sure that had this case been treated by prompt aspiration of the sac, and the proper use of the rubber bandage, a perfect and rapid cure would have resulted without a week's confinement of the patient to her bed.

## THE EPIDEMIC AT PLYMOUTH, PA.

The town of Plymouth is at present unenviably famous. The occurrence of over a thousand cases of undoubted typhoid fever in a population of eight thousand has drawn the eyes of all medical men to its sanitary condition, and to the relationship between this and the outbreak of the disease. Never has a widespread epidemic been more clearly traced to its true source, and never has neglect of sanitary precautions been more promptly and severely punished. Before hygiene had reached a state of accuracy and taken its position among the modern medical sciences, such afflictions were counted among the visitations of an inscrutable Providence; but to-day we know that such visitations are not due to the unsearchable workings of a distant, mysterious power, but are the legitimate effect of flagrant violations of sanitary laws.

The investigations of the resident and visiting physicians all point to the conclusion, that the water-supply of Plymouth has been the agent in the propagation of the virus of the disease. Plymouth receives its water chiefly from a pure mountain stream; the water is stored up in four successive reservoirs, from the last of which pipes lead to all the streets of the town. When the water in this stream is very low, the pipes are supplied with water pumped directly into the mains from the Susquehanna River. This was done from March 20th to March 26th; but the river water was then reasonably pure, and no suspicion is attached to it. It was suggested that the mountain stream supplying the town might be at the bottom of the trouble; and a committee of three resident physicians was requested by the Water-works Company to investigate the condition of the reservoirs and streams.

The committee found that the stream was supplied with an abundance of pure water. Between the third and fourth reservoirs, however, in the only house situated upon the stream, there was a patient convalescing from typhoid fever. This patient visited Philadelphia on December 25, 1884, and returned home on January 2, 1885. It is presumed that he contracted the disease in Philadelphia, though the condition of the town itself, according to competent report, was bad enough to generate typhoid fever or any other disease; it does not matter where he took the disease, the fact remains that he had it. He partially recovered and suffered from a relapse, and on March 18th and 19th he had severe hemorrhages from the bowels that imperiled his life. During his illness the dejecta passed at night were thrown out on the snow within a few feet of the stream and without any attempt at disinfection; while the day-stools were



emptied into a privy, the contents of which lay upon the surface of the ground. The dejecta accumulated and remained innocuous upon the snow. From March 25th to March 31st the weather was sufficiently warm to melt large quantities of snow, and early in April there were frequent showers of rain with mild, warm weather. The thaws and rains washed the dejecta into the stream, whence the poison was sent to all parts of the town.

"Supposing that this occurred between March 25th and April 5th, and allowing from ten to fourteen days as the proper period of incubation, we would expect, from this cause, an outbreak of typhoid fever to occur from the 5th to the 15th of April. The time of the proven contamination of the water supply, allowing the proper time as the period of incubation, corresponds so thoroughly with the onset of the epidemic, that the committee could but conclude that in this explanation sufficient cause was found for the epidemic of typhoid fever in Plymouth." (Dr. Lewis H. Taylor). Six hundred feet below the contaminated reservoirs there lives a family in which two persons had typhoid fever; the family dipped their water directly from the stream, below the point where the dejecta were washed into it. A little further down is a house in which hydrant water (*i. e.*, from the reservoirs) was used; the disease was prevailing in that house when the committee was investigating.

Only sixty feet away from the last one, stands a house supplied with well water; the family escaped. A short distance to the north there were eleven families using well water; none of these families were visited by the disease. On one side of a certain street, almost every family using hydrant water was stricken, while the families living on the other side of the same street, using well water, escaped. This was observed to be the case on several streets. Many other cases and phenomena indicate that the epidemic arose from the contamination of the drinking water of the town with the dejecta of one typhoid fever patient.

It is a very easy and cheap matter to destroy the infective properties of typhoid fever excretions; and when we reflect that a little instruction to the family might have averted the terrible calamity that has befallen a thriving town we are more than ever convinced that health authorities should institute a prompt surveillance over all cases of infectious disease, and should take the necessary steps for stamping out a plague.

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## THE ABUSE OF MORPHIA IN MENSTRUAL SUFFERING.

Many ladies afflicted with uterine disease suffer but little inconvenience from the local changes throughout the inter-men-



strual period: hence attention is not directed to these conditions; medical advice is not sought and it is only in the intense suffering which precedes or accompanies the flow that the physician is called. All the usual hot applications, external and internal, have probably been tried: he must do something, and by an hypodermic injection, or a dose of morphine, quiets his patient and leaves her satisfied that he has succeeded. She is satisfied because her sufferings are relieved, and the physician is equally satisfied that he has effectually accomplished what he was summoned to do: he has relieved the pain: but this recurs month after month: the local disease, uterine or ovarian, is not improved: on the contrary, most probably grows slowly worse, so that the nervous system of the patient, or the stomach, suffers from the constantly increased dose of morphine.

Unfortunately the same treatment is but too often resorted to by the specialist, when, after months of treatment, the same menstrual suffering recurs. At first he uses it merely to afford temporary relief: but should the desired improvement not follow, after all possible means have been tried, he again and again administers the same dose, and the same unfortunate result to the patient follows. Digestion is impaired, the nervous system shattered, and the mind finally suffers. Those who object to the use of morphine or opium under the circumstances, give whisky, and the unfortunate patients take glass after glass, until their sensibilities are dulled and the pain at least becomes bearable. The stomach often suffers so that the patient barely has time to rally when she must again pass through the same ordeal.

We would not for a moment deny the propriety of relieving excessive suffering for the time being, or of administering the drug in those cases when it may have a curative effect, but it must be given only if the physician is for the first time confronted with a patient in the agony of the menstrual suffering, when he is acquainted with the case, when he must act at once and other treatment is out of the question: or if the menstrual period should appear, in consequence of a cold or over-exertion, with unusual severity: but when it has passed, treatment must be inaugurated so as to prevent the recurrence of such suffering.—*American Medical Digest.*

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## COCAINE IN THE TREATMENT OF INFLAMED NIPPLES.

The limits of usefulness of cocaine do not seem to have been reached. The sphere of its therapeutic activity, is on the contrary, constantly increasing. One of the peculiar features of the

remedy is the promptness and constancy of its action. Its latest employment is that advanced by Unna in the treatment of inflamed nipples, in which affection he holds it has no rival in marvellously removing both pain and soreness. Every physician knows how troublesome and difficult it is to cure a fissured nipple if a baby is nursing it. To afford prompt relief, even while the child nurses, has not been hitherto accomplished. Cocaine is said to have succeeded in all cases tried by Unna and others. The nipple is to be brushed every ten minutes, in the intervals of nursing, by a weak solution (one-half to one per cent.) of the hydrochlorate of cocaine. Within one or two days the fissure will have healed completely, and all pain consequently will have completely disappeared. The bitter taste of the drug does not prevent the child from nursing, nor is there any danger of its absorption and consequent untoward effects in the child. It would even possibly benefit the child when irritable and restless. —*Therapeutic Gazette*.

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## EUCALYPTUS IN THE TREATMENT OF TYPHOID FEVER.

Leighton Kesteven, of Brisbane, Queensland (*The Practitioner*, May, 1885), having made an extended trial of eucalyptus in the treatment of typhoid fever, both in hospital and in private practice, was so pleased with the favorable results obtained that he now warmly commends the drug to the profession for further trial. Of two hundred and twenty cases of the disease which he attended in about eighteen months, there were only four deaths. He gives ten minims of drug every four hours. "Without being absolutely nauseous, this medicine does not agree well with all stomachs, but this difficulty can be entirely overcome by careful emulsification, and the addition of half a drachm each of aromatic spirits of ammonia, spirits of chloroform, and glycerine, the latter entirely removing the rough semi-resinous taste of the oil. The effects of this medicine are, in brief, the following: First, it steadily and permanently reduces the force and frequency of the pulse. Indeed in one or two cases I notice this result obtained with almost marvelous rapidity; in one case in particular, the pulse, from being a sledge-hammer pulse of 120, went to 90 within an hour of the first dose of the medicine, and never went above 90 again. Secondly, lowering of the temperature. This occurs less rapidly, and (it has occurred to me) might be entirely secondary to, and dependent on, the lowering of the pulse. The beneficial effect on the tongue is very marked, almost immediately alleviating the distressing dry-

ness so universal in typhoid, and removing the thick brown coating, leaving but proportionately little fur, and frequently cleaning the tongue entirely in a very short time. Fourthly, the skin, along with the reduction in its temperature, becomes moist and soft in contrast with the harsh, dry, hot skin so frequent and persistent, conferring a corresponding increase of comfort to the sufferer, who has frequently felt as if his skin had been drawn tight all over his body. This alone is a boon to the patient of no small import."

Concerning diet and general treatment the author says: "In all severe cases I order whisky from the commencement of the case until normal temperature is attained, giving on an average five to ten ounces per diem, usually in milk and soda-water. In ordinary cases I feed the patient on milk thickened with isinglass, beaten-up eggs, milk and soda, coca, and—where diarrhœa exists—ground rice and milk. In asthenic cases chicken-broth (concentrated to ten ounces of clear broth from a whole fowl) given in ounce doses to avoid filling the stomach with too large a quantity of fluid for weak digestion, the juice of half-cooked mutton, or beef tea made in a pot without water and strained through fine muslin. For the abdominal tenderness frequently changed ice-cold compresses, and ice to suck; ice to the shaved head for cephalagia; and frequent cold packs from the head to the knees at any rise of temperature. All the linen is changed morning and evening, without ever altering the patient from the horizontal position. All nourishment is given in small quantities at short intervals, thus receiving better digestion than when given in larger quantities at longer intervals."—*Medical Record*.

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## EMMET'S OPERATION: WHEN SHALL IT AND WHEN SHALL IT NOT BE PERFORMED?

1. It is evident that the operation has been performed unnecessarily for symptoms similar to but other than those arising from lacerations of the cervix. Further, that it has been done imperfectly, even without preliminary treatment, in many more; and the failure to give relief as reported by several, is due to these two causes.

2. That from our present knowledge we cannot, at this time, arrive at any definite conclusion, from the fact that many of the so-called consequences of lacerations of the cervix uteri are not settled beyond doubt.

3. That every one engaged in this department should carefully select his cases, and try every known means to give relief before recourse is had to operation.

4. The operation should never be performed *co ipso* in cases of simple fissures or lacerations of first and second degree.

5. In cases of aversion and disease of the cervical or corporal cavity, or both, although attended by hyperplasia and displacement, it has been observed that all the symptoms abated and the parts returned to their natural condition, and that no laceration was discoverable after alleviative measures were instituted first, which alone caused the parts to return to a normal condition.

6. There are some cases of extensive laceration of cervix that seldom give rise to any inconvenience, and that, therefore, an operation should be deferred until symptoms arise that will call for its performance.

7. The operation, although indicated, should never be performed until, by preparatory treatment, the parts have been brought into a healthy condition.

8. Near, and during the climactic period, the operation should be postponed as long as possible, and the patient not exposed to any risks, since in many cases all the symptoms subside under proper treatment, and never return under senile involution.

9. The operation is justifiable in cases of lacerations of the third and fourth degree without complications, if there is a history of malignant disease in the family.

10. The operation may be performed with perfect propriety in young women, as a preventive, if the laceration is bilateral and extends up to the cervicovaginal junction, or beyond it even though there are no pathological changes; indeed it seems to be the duty of every one who observes a lesion to that extent, to urge the operation.

11. The operation is justifiable in any degree of laceration, and in rare instances even in fissures, when there exist cicatricial tissues productive of reflex disturbances, annoying in character, and not tractable to any other treatment.

12. The operation is absolutely indicated in all extensive tears of the os, or in which the cervix is everted, its mucous membrane and Nabothian follicles diseased, and especially if there be granular or cystic degeneration present, provided the parts have first been restored to a healthy condition by palliative treatment.—*Dr. Zinke.*

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### MANGANESE IN AMENORRHŒA.

My attention was arrested some two years ago by an article on the use of binocide of manganese in amenorrhœa due to hygienic imprudence at the menstrual nixus, disturbances, etc. A



short time thereafter a Miss N., aged seventeen, came under my care. She had taken a severe cold at a dancing party, from the effects of which her menses, which were then on her, became suddenly suppressed. She presented symptoms of decline, with hectic, nervous chills, dry cough, and general malaise. After having for a reasonable period tried the usual remedies without result, I concluded to test the virtue of manganese pills. I had an impression that the grave symptoms were due to the suppression of the menses, and that with these re-established, improvement would ensue. I ordered one pill to be taken at bedtime every night. After five pills had been thus taken the catamenia appeared and under the use of wine and iron the patient was soon restored to her original good health.

I have since had two similar cases, which I treated in a similar manner with similar results. In one of these the suppression had existed for several years, and had been treated by eminent physicians both of Michigan and of the West, whither she had been sent in the hope of benefit from the change of climate. In this latter case fifteen pills taken nightly in the course of two weeks, in combination with tonic diet and medicines, wrought such a change that the patient became a regular patron of the roller skating rink, where she would exercise for two hours at a time without fatigue. The remedy is certainly one of great power in amenorrhœa.—*Dr. A. R. Hicks, in Medical Age.*

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## TREATMENT OF ANGINA PECTORIS BY THE IODIDE OF SODIUM.

Angina pectoris since the days of Gintrac and Lancereaux has been considered as a cardiac neurosis. Although in many cases a diseased condition of the coronary arteries and the aorta has been found, still the symptoms have been ascribed to a nerve disturbance dependent more or less on the innervation of the heart muscle or upon some degenerative change of the nerve fibres. M. Henry Muchard, from a study of twenty-five post mortem examinations made at "Hospital Vichart," objects to this view and ascribes the symptoms directly to degenerative changes with obstruction of the coronary arteries. He claims that true angina pectoris is the result of a disease of the arteries and not of the nervous system.

In accordance with this theory he advises remedies which have an effect on the arterial system. The iodide of sodium is especially recommended, given in doses of sixteen to thirty grains daily. He continues this medication during months and even

years, and claims to have given complete relief and to have produced a cure of this dreaded disease in many cases. He thinks that the iodide of sodium probably acts by lowering the blood tension, relieving the walls of the artery and favoring the disappearance of the pathologic exudation. For the relief of the paroxysm he recommends the inhalation of the nitrite of amyl in four to six drop doses.

Although true angina pectoris had been assumed to be a neurosis, the remedies which have been mostly successfully employed have been those acting upon the arterial system. Occurring as it does at the ages when degenerative changes in the arteries are found and in subjects of such degeneration, it would seem that the theory advanced by Huchard should be carefully considered. That it is generally accompanied by high arterial tension has been already recognized, and the drugs have been most successfully used which reduced this tension. Dr. Lauder Brunton has long since recommended the nitrite of amyl in reducing blood pressure, and we are indebted to Dr. Murrell for our knowledge of the value of nitro-glycerine as a remedy producing the same result. Both remedies have been successfully employed in relieving attacks of angina pectoris, but neither have been able to effect a permanent cure.

That the iodides from their well-known action of lowering the blood pressure and at the same time favoring the disappearance of pathological exudations may exert a healthy action in the earlier stages cannot be denied, but in cases connected with well-developed atheroma more evidence is needed before it can be positively accepted.—*Courier of Med.*

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## ON CARDIAC WEAKNESS.

The functional disorders of the heart presenting themselves so frequently and in so varied expressions to the practitioner are not infrequently a severe tax upon his diagnostic acumen and his capacity to afford relief.

Aside from the cardiac depression resulting as an expression of sympathy from some existing pathological condition in the system, or some definite organic lesion, there is a functional weakness of the heart, due to faulty innervation of that organ. Dr. Seeligmuller, of Halle, speaking before the last meeting of German physicians in Madgeburg, held that this form of cardiac weakness could always be traced to two causes, viz., habitual sexual excitement without corresponding satisfaction, and continued intense brain-work with insufficient allowance of sleep.

In the more definitely developed cases we find general weakness, excitement, and palpitation of the heart, pains in the epigastric region, profound reaction after even moderate physical or mental exercise, deepening occasionally almost into coma, persistent insomnia, hyperchondriacal depression, failing nutrition in spite of good appetite, pallor, and slight cyanosis of the extremities and naso-labial region, and occasional fomication in hands and feet. If we examine the heart at different times of the day we can alwas note the weakness of the apex-beat and the heart-sounds, and the smallness of the pulse. The state of inanition is most favorable to present all symptoms of cardiac weakness. After arising, such patients usually have a pulse of about 40, after breakfast of about 50, and do not obtain a pulse of 60 before taking some wine or eating some meat. The normal frequency of the pulse is scarcely ever or only transiently reached. In very pronounced cases we meet with steno-cardiac paroxysms. Next to this persistent extreme cardiac weakness there is a mild, intermittent form often connected with great excitability of the heart (irritable weakness). Every excitement causes palpitation, tea or coffee insomnia, in these patients. It is difficult to decide in the single cases whether the seat of the neurosis be in the pneumogastric or sympathetic nerves or in the medulla oblongata. Intense mental impressions, no matter whether of a pleasant or unpleasant nature, tend to aggravate the existing evil. Persisting pains, neuralgic in especial, and traumatic accidents, cause likewise a frequent aggravation of the affection. Women having passed through confinements often complain of this ailment, possibly on account of the concentration of the blood in the abdomen. Improvement is generally obtainable in these cases by the wearing of a suitable abdominal bandage. In persons of an advanced age abnormal dilatation of veins in the lower extremities often leads to cardiac weakness.

The therapeutical measures to be employed are chiefly related to proper physical exercise, regulation of diet, and change of air. A sufficient allowance of sleep, especially before midnight, is to be insisted upon, and resting during daytime, even if sleep is not obtainable, is to be recommended. All violent physical strains are to be strictly avoided, while methodical, moderate gymnastical exercises, especially walking, are salutary. Forced cold-water cures are injurious, while warm baths, taken several times a week, are indicated. The diet ought to be strengthening and abundat. Coffee, tea, alcoholic stimulants, and tobacco are to be entirely avoided. A prolonged stay at the sea-shore or in the mountains has often proved a benificent measure. The thermo-baths of Gastein enjoy an especial reputation for this affection.—*Therapeutic Gazette.*

## PARALDEHYDE IN PLACE OF CHLORAL.

A correspondent to the *Lancet* states he has used paraldehyde as a hypnotic in place of chloral, and prefers it to chloral for the following reasons :

1. There is no excitement preceding its hypnotic action.
  2. It has no paralyzing effect on the heart.
  3. It acts more quickly.
  4. The sleep produced is more natural : it is dreamless and refreshing : the patient is easily aroused, and when left alone readily goes to sleep again.
  5. There are no unpleasant symptoms; no confusion of ideas when the patient awakens: no headache: no loss of appetite, even when the drug is long continued in large doses. The writer had used the drug about 150 times. The dose is from thirty to ninety minims, but the maximum dose is seldom needed to produce sleep. Smaller doses repeated every hour are preferable to large doses not so frequently repeated.—*Chicago Med. Times.*
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## BROMIDE OF ETHYL IN OBSTETRICS.

If possible to obtain some remedy with which to lessen the pains of the woman in labor and less dangerous than chloroform, it certainly should be done—and all investigations in this direction have a worthy object.

Nunnely, as early as the year 1849, used the bromide of ethyl in surgery. He appears, however, soon to have abandoned it, subsequently it was used in America.

E. Rose, on the recommendation of Tumeville, had used it to complete narcosis. He, however, did not especially recommend it. M. Lebert (*Arch de Tocologie*, 1882) was the first person to use it in obstetrics. C. Wiedeman investigated later concerning hydrobromide of ethyl as an anæsthetic in child-bed (*Petersberger Med. Wochenschrift*, No. 11, 1883) also Hæckermann (*Gynakol-Centralblatt*, No. 34, 1883). Both testified that the bromide of ethyl lessened or entirely dispersed the labor pains. This, too, without danger to the mother or child, and without influence on the course of the labor and without loss of consciousness. As to the physiological action of the bromide of ethyl. From the investigations of Rabuteau, it is better borne than chloroform. It works faster, but does not continue so long in its effect, as it passes off from the lungs very rapidly.

Prof. Dr. Muller in Berne (Berlin Klin. *Wochenschrift* xx 44, j. 73, 1885,) had used this remedy in twenty-two cases of



labor. He was quite contented with his success, does not, however, keep the imperfections of this medicine a secret. The cases consisted of sixteen primipara and six multipara. Inhalation was conducted in the same manner as with chloroform—on an average 60 grammes was used. The patient showed no disturbance from the smell of the medicine, and after the inhalation suffered from neither vomiting or nausea. With smaller doses consciousness remained undisturbed. In nine cases M. observed a slight acceleration of the pulse and respiration. He frequently observed rapid dilatation of the pupil and flushing of the face. From this fact, anæmia of the brain, as in chloroform narcosis, was not to be feared from this remedy. It is peculiar that the anæsthetic acts quite promptly on the fœtus. It does this, however, without occasioning any harm. The peculiar smell of the bromide of ethyl can be noticed on the breath of the child. The anæsthetic action of this remedy is often surprising, and the benefit from it in restraining abortion in multipara is remarkable.

The imperfections of this remedy were observed by M. to be of three kinds. Insufficient labor pains occurred in five cases, which must probably be laid at the door of the remedy. This, however, was caused only to a slight degree, as it was not found necessary to complete the labor in any of these cases artificially, and that there was no post-partal hæmorrhage. Disturbance in the respiration was also observed in two cases. The symptoms were those of an acute bronchitis, which was especially severe in the second case. For all that both patients were discharged well, one in ten days, the other in fourteen days.

It appears that with this remedy also the individual sensitiveness is different. The third objection is that in many cases 50 per cent. of those observed by M., the remedy did not act, so that one cannot reckon on it. This failure was observed in using it in the period of expulsion as well as in that of the dilatation. M. thinks further observations very desirable.

In the article by Hæckermann (*Zeitschrift für Gebh. u. Gynæcol* x. p. 122), we learn that he has used the bromide of ethyl in same manner as chloroform in fifty parturient women. The stage of excitation which Hæckermann, differing from other observers, says is increased, precedes the stage of anæsthesia or analgesia.

After about fifteen inspirations had been taken, prickings with a pin in different parts of the body were not noticed at all, or very little. The senses remained completely preserved. The bromide of ethyl appeared, according to Hæckermann, to have no influence on the activity of the pains. The quickest power to quiet and ease pain was often noticed toward the close of the period of expulsion. This also insures the mother freedom from

pain on the passage of the child's head through the vulva. With a little deeper narcotization the patient had no feeling whatever, and gave no answers to questions. Häckermann used this grade of narcosis when he used the forceps. Consciousness returns very soon, so that the woman often believes she has not yet been delivered. Nausea and vomiting never occurred. Post-partial flooding was never observed. The deep narcosis which he produced in three cases is not to be recommended. He thinks that the bromide of ethyl can serve only to conduct a painless delivery.

Parnemann, of Elspe *Med. Cent. Zeitung*, No, 86, 1883, used the bromide of ethyl with a normally built primipara in this manner: She was allowed to breath it in the one breath and omit it in the other. At the first inhalation about ten inspirations were necessary to induce local anæsthesia. In a later trial two deep inspirations were sufficient to render the pains imperceptible. Parnemann was convinced that the pains averaged longer in duration and were of normal strength, and that no special rise in the pulse rate was noticed, while the number of pains per minute without the bromide of ethyl was 2,  $1\frac{1}{2}$ , 2,  $1\frac{1}{3}$ , they rose after inhalation to  $2\frac{1}{2}$ , 2,  $2\frac{1}{3}$ ,  $2\frac{1}{3}$ . The delivery was completed with the forceps without increased pain. The patient, during the whole delivery was conscious, and no untoward results followed. How long the bromide of ethyl should be inhaled as well as the indication for the laying on of the forceps is not given.

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### CREASOTE WATER IN BURNS.

Creasote water is a simple 1 p. c. solution of wood creasote in water, and like similar solutions of carbolic acid and of cresol, it is a most effective local anesthetic, and topical dressing to burns and scalds. This creasote water—or diluted with an equal volume of water, or with more water for delicate surfaces in women and children, and applied by means of a single thickness of thin muslin, or worn out cotton or linen, such as handkerchief stuff, and the application renewed from time to time, as the return of pain requires it, will relieve the pain of burns and scalds in five to ten minutes, and will maintain the relief as long as the applications are properly renewed, or until the painful stage is over.

It is also very effective as a local anesthetic for general use in all painful conditions which effect the surface only, such as the pain of erysipelas. The benumbing effect of these phenols upon the skin is very promptly reached, and can be carried to almost

any degree that is desirable, by simple management of the strength of the solutions and the mode of application. They are true anesthetics to the skin, while the much lauded cocaine is not.

The statement has been published so often during the past twenty years, and the treatment has been so effective in so many hands, that it is wonderful to notice how the common practice is still to use the old and comparatively useless and hot dressings, such as carron oil, white lead ground in oil, flour liniments, etc., or the newer application of solution of bicarbonate of sodium.—*Squibb's Ephemeris*.

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### TREATMENT OF CARBUNCLE BY OLEATE OF MORPHIA.

In the course of a paper read before the Indiana State Medical Society, 1885, by Dr. James F. Hibberd, of Richmond, Ind., and published in the *Indiana Medical Journal*, May, 1885, the author makes the following remarks :

At the late meeting of the American Medical Association at New Orleans, Dr. L. D. Bulkley, a distinguished dermatologist of New York, read the first paper before the section on Practice of Medicine, entitled, "The Treatment of Carbuncle Without Incision." As his paper will soon be published,\* it is not my purpose to rehearse his views here, but to simply say that he announced that the treatment of carbuncle by the orthodox crucial incision, poultices, other hot applications and ointments, had been so unsatisfactory that for several years he had abandoned them all and substituted soothing applications of special mixtures, the composition of which he detailed, for the most part applied on cotton or the pilr side of patent lint, and paid particular attention to the constitutional treatment, insisting upon the value of supporting measures, tonic medicines, and the sulphide of calcium as a means of limiting suppuration. Dr. Bulkley detailed a number of cases, some of them quite severe, which he had managed under his new views with much better success than formerly, though his patients still went through the usual phases of the malady, but not occupying the full time period of seven weeks as of old, nor did they suffer the former serious local pain, nor the general constitutional depression.

As I had had a new experience in the local treatment of these painful and exasperating tumors within the last twelve months with a preparation to which he made no allusion, although exactly in line with his advanced views of the best man-

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\*See Peoria Med. Monthly, Vol. vi., No. 1.

agement, I ventured, in the discussion of the paper, to make a plain statement of my experience in this behalf, and while it is not of sufficient extent to lay claim to an established treatment, it seems to me of sufficient importance to repeat here that practitioners may make trial of the remedy and determine whether my cases were happy co-incidences or a substantial advance of our knowledge in the local treatment of carbuncle.

The application I desire to call attention to is the oleate of morphia, and to illustrate my experience I will present the details of the first and the last cases where I made use of it :

On the 30th of April, 1883, T. N., an active business man of general good health, about sixty years old, applied to me for a painful swelling on his neck to the left of the ligamentum nuchæ, a little below the line of hair.

Telling my patient that he had carbuncle, and was likely to have several weeks of great local suffering and much general depression, I gave him some oleate of morphia, with careful instructions how to apply it, expressing the hope that it would do something to mollify the pain if nothing more, and this I did because of my experience in alleviating other painful conditions of the skin and subcutaneous tissue with this preparation of morphia. It was also to be applied to the nodules forming near the principal swelling. The patient returned the next day, and quite to my surprise and gratification, stated that nearly all pain had ceased in the large tumor, all was gone from the smaller ones, and the soreness and stiffness of the neck had greatly diminished. On examination the smaller tumors were shrunk and no longer irritable, and the larger one had lost something of its boggy feel, was apparently smaller, was but slightly sore, and the skin over it was more natural in appearance. The application was continued, and at the end of three days all pain and tenderness had left the neck, the smaller tumors disappeared, and the larger ones had the characteristics of a calloused indurated swelling under the skin, about half the dimensions of the original tumor, and this was absorbed in about a week or more.

Two or three months subsequently the patient had another disturbance near the same spot, beginning in an irritable pimple as the former one had begun, but a few applications of the same remedy applied by my direction arrested all further development.

On the 24th of April, 1885, Mr. J. W. G., aged eighty-six years, sought my advice for a tumor on the back of his neck, to the right of the ligamentum nuchæ, which was giving him much pain and anxiety. It proved to be a carbuncle an inch and a half in diameter, with a point of superficial suppuration on top.



An inch below the main tumor was a smaller one, an irritable pimple such as the larger one was in the beginning.

The swelling was of several days standing, and a part of the skin covering it so inflamed that I feared the oleate of morphia could not be used with the success that otherwise I should have hoped for. However, I gave him the preparation, with instructions for its diligent and proper use, but explained to him why it might fail, and advised him, if he had no relief after a fair trial, to consult another practitioner, as I should leave for New Orleans on the afternoon of the next day. But at noon the next day the old gentleman reappeared at my office with a smiling countenance to give me some good news, as he averred, before I left, stating that the soreness of the tumor was nearly gone, the stiffness of his neck but trifling, and the pain so promptly relieved that he had had a good night's rest, the first of the kind since the swelling began. On examination the soreness of the smaller tumor was removed, and that of the larger one greatly diminished, and its appearance and feeling altered for the better, while the superficial point of suppuration was discharging but little and the surrounding inflammation of the skin greatly subdued. Treatment was directed to be continued, and when I returned and examined the seat of disease ten days later, there still remained a small indurated nodule under the skin, but no soreness, no pain, nor other inconvenience, and to this condition it had been steadily approaching since my last previous examination. \* \*

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### ULCERATION OF THE BOWELS IN YOUNG INFANTS.

The author uses as diet, where milk is not borne, even with lime water, one part of cream, two parts of barley water, two parts of whey, with the addition, from time to time, of white of egg mixed in water with beef essence. When the secretions are mainly mucopurulent, small doses of castor oil (8 min.) with tincture of opium. After this character is lost and they are simply thin watery passages—astrinents are indicated. He emphasises the beneficial results obtained during convalescence from the administration of the lactophosphate of lime and iron. Of this he give 10 min. of the syrup three times a day.—*Practitioner*.

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The sum of 25,000 francs has been given to the Academy of Medicine of France, to be awarded as a prize to any one discovering a remedy recognized by the Academy as efficacious in diphtheria. Until the award, the interest is to be paid every two years as awards for the best research on the disease.

## FOR DYSPEPSIA.

Professor Pancoast likes a combination as follows:

R. Elix pepsin. et bismuth.,	3 ozs.	
Ext cinchonæ fld.,	1 oz.	
Elix. zingiberis,	1 oz.	M.

Sig.—Dessertspoonful at meal time.

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## ITCHING OF THE SKIN.

Professor Bartholow says that itching of the skin, from any cause, can be allayed by sponging the patient with—

R. Acid. carbol.,	2 dr.	
Glycerini,	1 oz.	
Aquæ rosæ,	ad	8 ozs. M.

Sig.—Lotion.

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## SUPERFICIAL NEURALGIA.

For superficial neuralgia, the following will often be found of benefit. (Prof. Bartholow.)

R. Ol. caryophylli,		
Ol. gaultheriæ,		
Ol. thymi,	aa	1 dr.
Tinct. benzoini,		
Tinct. cinnamomi,	aa	4 ozs.

Sig.—External use.

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## MEMBRANOUS ENTERITIS.

Several cases of membranous enteritis were shown in Prof. Da Costa's clinic. The treatment consisted in keeping the fecal accumulation in a soluble state by—

R. Magnes. sulph.,	2 ozs.	
Ferri sulph.,	2 dr.	
Aquæ,	2 pints.	M.

Sig.—Take every morning  $\frac{1}{2}$  ounce.

Also—

R. Liq. potassi arsenitis,	2 drops.	
Tinct. ignat. amaræ,	6 drops.	
Tinct. cinchon. comp.,	1 dr.	M.

Sig.—Ter die.

# THE PEORIA MEDICAL MONTHLY.

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THOS. M. MCILVAINE, A. M., M. D.,

*Editor and Publisher.*

204 S. JEFFERSON St., PEORIA, ILL.

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\* \* \* The Editor is not responsible for the statements or opinions of contributors.

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\* \* \* If extra copies are desired by a contributor, the number must be specified when the article is sent to the Editor.

\* \* \* All exchanges, books for review, and communications must be addressed to the Editor and Publisher.

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## EDITORIAL.

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### THE LATE PROPOSED MEDICAL CONGRESS.

The war continues, and the breach between the opposing forces widens with each successive week. So far as we know actual blows have not been passed, but the amount of wind expended will soon be sufficient to blow the whole craft out of the water. (That may not be very elegantly or correctly stated, but you know what we mean and the weather is too hot, 98° in the shade, for further correction).

The Philadelphia protest and withdrawal contained twenty-eight names, that from Boston nineteen, and Baltimore twelve with more to hear from. Twenty-seven from New York were ignominiously bounced, and the list of officers and committees as it now stands is bereft of such names as Loomis, Emmet, Bulkeley, Keyes, Lefferts, Mundé, Knapp, Bosworth, Packard, Da Costa, Bartholow, Pepper, Mitchell, Gross, Hays, Agnew, Parvin, Goodell, Leidy, Stille, Yandell, Williams, Blake, Chadwick, Chisolm, Johnston, Mackenzie, Lee, Tiffany, Theobald, Johnson, Burnett, Prentiss, Baker, Huntington, Engelmann, etc., etc., etc.

Poor Congress! it looks as if it had "died abornin'," or at least was having a awful hard time to get started into this world (western part of it) of sorrow and contention. The office of

Secretary-General is vacant. The sections of Therapeutics, Medicine, Anatomy and Surgery are without heads, and other sections are partially dismantled. And still the fight goes on.

The "Father of the American Medical Association," if not of American medicine, has not been acting as he should have done in the premises. Instead of taking the rebellious children over his paternal knee, and spanking sense into them, he has been poking fun at them, and joking them over their discomfiture, thereby only adding to their grievances. It is too hot weather to record more of the "squabble" for that is hot enough itself for midsummer, so will refrain from making any remarks, and simply give the facts as we have done above. Another chapter will follow, but the history will not be completed for many months to come.

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#### A NEW STAR.

Daniel's *Texas (Star) Medical Journal* has made its appearance in flaming red, and will sweep the western medical sky like a comet of the first order. No, that will hardly do, for a comet is transitory while the *Star* has come to stay, and we hope it will stay; long and bright may be its career. May it shed light into the bentghted State that has but one other medical journal, and produces a million and a half bales of cotton a year. Shake, Brother Daniels, and accept our sincere congratulations on the contents and appearance of your handsome monthly.

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#### "A LIVELY AND NEWSY MEDICAL JOURNAL."

One of the solid medical journals of the West, the *Cincinnati Medical News*, pays the following compliment to a certain cotemporary in which we are somewhat interested. Modesty forbids our commenting upon it:

"A lively and newsy medical journal is always interesting to us, and we always take pleasure in reading such a one. It may not always contain as large an amount of solid scientific information as some slow-plodding medical publication, like the *Boston Medical and Surgical Journal* and the *American Jour-*



“*nal of Medical Sciences*, but, notwithstanding, it subverses a useful purpose. It stimulates the mental energies, directs the thoughts into new channels, and often discovers facts of practical importance that might have remained concealed. One of the liveliest and newsiest medical journals with which we are acquainted, is the PEORIA MEDICAL MONTHLY. We propose to make a few selections from it.”

And it makes good its word by liberal extracts from our “Notes and Comments.”

### IS FERRAN A CHARLATAN?

The idea of inoculation for the prevention of cholera produced considerable stir in the medical world when it was announced that a Dr. Ferran had discovered the true method and was successfully practicing it in the cholera-stricken provinces of Spain. There was little in the nature of his claims to warrant anything more than a hope that his assertions might be based upon truth, and that the world was to be enriched by a second Jenner or Pasteur. Still, the fact that one attack of cholera does not give immunity from other attacks made it impossible that any system of vaccination or inoculation would offer any protection against the disease.

An American physician writing to the *Chicago Daily Tribune* gives the results of his visit to Ferran at Alcira in Spain and the results of his investigations into the methods employed.

He found the people enthusiastic about inoculation, and fighting for the privilege of being inoculated.

The first observation made was as follows:

I at once sought out an inoculated person and opened up a clinical study of his symptoms. He had been “touched” at 9:30 A. M. of a Monday and I saw him the next day at noon. There was great and intense constitutional disturbance, with fever, vomiting, and diarrhœa. But the symptoms were not choleraic, though bacilli were found in the blood and evacuations. There was a notable nausea, with heat and pain in the stomach, and exquisite intestinal tormina following. Restlessness, palpitation, and headache were marked, and within twelve hours from the time I met him the patient had the objective phenomena of true choleraic collapse, and the discharges resembled those of cholera. But there was no cholera about it. The diarrhœa of cholera has

the merit of being painless, and this was not. Moreover, there were really no signs of what cholera should be. There was some vomiting, and much hebetude, great weakness, and considerable fever. In fine fact of deed something of a "state" had been produced, but I would have defied any one to have diagnosed it as cholera or as a semblant state. The observations settled nothing in my mind.

He then sent his card to Dr. Ferran but it was not noticed. A note asking for an interview met with a like silence. He then feed an officer to give him admission and introduced himself as an American student of Koch, stating that he wished to learn something regarding inoculation.

"I do not propose to acquaint you or anyone else with my secret" was Ferran's reply: "it is my property and is not to be revealed, though ultimately I may sell the right to use it in other countries than Spain. You would *steal* my secret," and the inquisitive American was shown the door.

This aroused his ire and he was determined to know more about it or perish in the attempt.

Accordingly he disguised himself as a countryman and and crowded again into the reception hall, presenting himself for protection by inoculation. What was done and how, we let him tell in the following extract from his letter:

He jabbed a sharp bistoury under my skin at a point just above my left elbow in a business-like manner. Then he took a bit of brownish unguental substance and inserted it under the integument, covering the wound up with a wafer of sticking-plaster, the whole proceeding reminding me of a rude way of vaccinating to protect from small-pox. The operation completed, the fellow told me that an eruption would appear at the seat of the vaccination, and that violent catharsis ("induced cholera" he called it) would follow. As an adjuvant to this, he gave me three little pills, bidding me take one after thirty-six hours, and the others after the seventy-second and 108th hours respectively.

Though I hastened to get out of the crowded hospital and to my hotel, that I might there examine the wonderful culture-fluid that I carried in my arm, some twenty minutes necessarily elapsed, and later I had the "symptoms." As soon as my door was closed I tore off the plaster and extracted as much of the unguent as I could. There may have been microbes in the stuff. I hope so. My analysis showed that it was a compound of some-

thing more than culture fluid. It was elaterium, and croton-oil, and vaseline, and perchance other ingredients. In the three little pills were the same drugs—both of them the most violent of cathartics. Subsequently I found that all who are vaccinated have to take the pills. The resultany physician or druggist can tell you.

The Doctor wonders at the smartness of Ferran in conceiving such a stupendous fraud, and humbly hopes he is not a “Yankee” in disguise.

Those who wasted so much admiration over the “Spanish student, studying amidst adversities and achieving that which would stamp out the plague and save millions of lives,” etc., will now refrain from raising a fund for him, or erecting his statue. He is sharp enough to take care of himself.

### FAMOUS LONDON DOCTORS.

We take the following chit-chat about famous London doctors from a little book recently published, called “London Society.” The only trouble is, that the list of these delightful pen portraits is so short:

I suppose there is no one who has terrified more persons into total or partial abstinence from intoxicating fluids than Sir Andrew Clark. Yet that distinguished doctor is frequently to be met with at the dinner-tables of the great and wealthy. Nor, so far as I have been able to observe, does he exclusively restrict himself to some aerated water, qualified by the most trivial infusion of Scotch whisky. He is a shrewd student of human nature, as well as, I doubt not, a considerable man of science—this canny Abderdonian.

Some years ago he conveyed to Mrs. Gladstone a deep impression of his powers. Mr. Gladstone recognized in him a careful doctor and a good High Churchman. The combination pleased the present Prime Minister, and Mr. Clark's fame and fortune were as good as made. His happy faculty of oracular utterances, the solemn aphorisms with which he clinches his counsel to his patients, the sonorous platitudes with which he emphasizes the simplest of sanitary maxims, his quick eye, the kind severity of his manner, the air of judicial sympathy with which he interrogates those who come to see him upon their maladies, the calm deliberation, the systematic shunning of the semblance of haste—these are the qualities which cause London

society to repose confidence in Sir Andrew Clark. Moreover, he is, when encountered in the dining-rooms of the metropolis, an agreeable and companionable person, with plenty of anecdotes and a gift of humor, the point of which is heightened by his Scotch accent. Sir Andrew Clark is a typical physician of his period, justly confident, doubtless, in his acquaintance with the British pharmacopœia, but confident rather in, and accomplishing more by, his comprehensive and microscopic knowledge of human nature.

Sir William Gull is endowed with all Sir Andrew Clark's command of noble and sagacious sentiments. If his prescriptions could be sometimes dispensed with it is worth paying a couple guineas for them, in order to store one's memory with the wise saws and modern instances of which he is full. His presence is more that of the ideal doctor than Sir Andrew Clark's. You could not, wherever you might see him, mistake him for anything but a doctor; whereas Sir Andrew might well be a lawyer, a farmer, a schoolmaster, or a parson. He plumes himself on his power of probing the secret hearts of his patients to their lowest depths by eagle glances and by pregnant and pithy pieces of professional sententiousness, enunciated in a melodramatic undertone. His manner is as perfectly calm and collected as is to be found in phlegmatic England itself. He can be kind and well as courteous: but whether he is simply the latter or whether he infuses into his demeanor something of the former, nothing appears to proceed from the spontaneous emotion of the instant—everything is prearranged. If he is not a great doctor as many hold him to be, he is a marvelous piece of human machinery.

The more purely social side of the medical profession is displayed by men like Dr. Quain and Sir Oscar Clayton. The latter of these I should pronounce without hesitation the nearest approach to the court physician of a century since, now extant. He is attached in his professional capacity to the household of the Duke of Edinburg, but as it was once said of an historical head master of Eton, that one could not help having a respect for a man who had whipped in his day the whole bench of bishops, so one's admiration for Sir Oscar Clayton is increased by the circumstance that he has physicked, for more or less serious, more or less noble, or ignoble, ailments the principal members of the aristocracy of England. It often occurs to me as I look upon this little knight of the lancet—well stricken in years, well made up, radiant in hair dyes and cosmetics, the secret of which rests with himself alone, deferential and insinuating in manner, with all sorts of stories calculated to suit every variety of audience, from a prelate to a demirep, at his disposal—that the spirit of



the courtly leech of the Grand Monarch or of the Caroline restoration in England must be enshrined in him.

Of Dr. Quain, certainly one of the most distinguished children of Esculapius—alas! that the child should now be marching toward the goal of septuagenarianism—it may be said that he is a cheery, kindly, genial, and a gifted Irishman first and a great physician afterward. Heaven forbid that when I say this I should hint anything like disparagement at that most worthy of doctors, that most staunch, omniscient, and fluently conversational of friends! Indeed, Dr. Quain is not only a Hippocrates of vast experience and profoundly scientific attainments, but a medical writer of the highest authority. He has produced within the last few years an encyclopædia of medical knowledge. How he found time for such a *chef d'œuvre* is the standing wonder to his friends. The explanation doubtless is that the doctor has an extraordinary appreciation of the value of time and diet for industrial purposes. He never loses an hour or a minute. The evenings that he gives to society recruit his energies for toil, and there is, I am informed, authentic testimony on record that Dr. Quain, after an evening spent with convivial friends, prosecutes his editorial labors, literary or scientific, until the bell rings for matins—a religious service that he usually makes a point of attending.

He is a perfect treasure-house of miscellaneous anecdotes, equally charming and various as host or guest, with a professional acquaintancé of men who have made their mark in all departments of life, which has usually ripened into a personal friendship unprecedented, I should think, in the history of the Royal College of Physicians. Several decades of London life have not destroyed his rich native brogue, but rather chastened it. He takes that easy view of life peculiar to prosperous, and for that matter unprosperous, natives of the Emerald Isle. He is, in a word, a medical philosopher of the epicurean type.

Dr. Morell Mackenzie is too entirely devoted to his profession to have much time to spare for the social distractions of Sir Oscar Clayton or Dr. Quain. He is probably one of the most gifted specialists in Europe, with one of the shrewdest heads on his shoulders. For these reasons he is not too much beloved by the members of his own fraternity. He is, however, as kindly as he is clever, and hospitable upon a big scale. This hospitality he shares in common with—though between the entertainments of the two there is no similarity—Sir Henry Thompson. The former is renowned for his big banquets; the latter for his small select parties, at which the number is strictly limited to eight. He calls them his octaves. At these you will find a company well assorted and easily amalgamated, dishes judiciously

**NON-ALCOHOLIC.**

**NON-RESINOUS**

**BLAND AND UNIRRITATING.**

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A definite and permanent solution of the Alkaloids of Golden Seal Root, viz:

**BERBERINA**—Of a bright yellow color, the salts of which are known in commerce as Sulphate, Muriate and Phosphate Berberina (Hydrastia.)

**Hydrastia**, crystallizing in white prismatic forms and insoluble in water.

**Xanthopuccina**, or the unknown third alkaloid, of a dark yellow color, but which has never been carefully isolated, and is unknown in commerce.

The use of **Fluid Hydrastis** is suggested in all affections of the mucous surfaces; correcting abnormal conditions characterized by profuse discharge of tenacious mucous, subcutaneous inflammation, erosions and superficial ulcerations.

## McDade's Prescription

—FOR—

**VENEREAL AND CUTANEOUS DISEASES.**

### FORMULA.

Fluid Ext. Smilax Sarsaparilla,

Fluid Ext. Stillingia Sylvatica,

Fluid Ext. Lappa Minor.

Fluid Ext. Phytolacca Decandra, a a, two ounces.

Tinct. Xanthoxylum Carolinianum, one ounce.

Mix—Take a teaspoonful in water three times a day before meals, and gradually increase to tablespoonful doses.

### CAUTION.

"In making the Fluid Extracts there is great risk of getting a remedy less efficient than the original Indian decoction, because the manufacturer may use roots that have been kept too long and lost some of their active principles; while the decoction used on the plantations was always made of Fresh Roots just gathered from the woods. In making the Fluid Extracts we should, therefore, be careful to have them made from roots recently gathered."

### REMARKS.

The WM. S. MERRELL CHEMICAL Co. of Cincinnati offer the formula of Dr. McDade, prepared in accordance with the principles so strenuously held by them for more than thirty years, viz. that the volatile elements of many plants are dissipated by the drying process, thereby injuring, if not wholly destroying, their medical properties.

**PRICE, \$12.00 per Dozen. \$1.25 per Pint.**

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*40, 41, 42 & 43 Central Wharf, BOSTON, MASS.*

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*A Sample of MELLIN'S FOOD, Sufficient for trial, will be sent free  
to any Physician desiring it.*

chosen, and sound wine. Sir Henry Thompson, who is indebted for his knighthood to the surgical skill he exhibited in operating on the august person of the King of the Belgians, is also an accomplished artist, and many of the most pleasant pictures which adorn the walls of his house are from his own brush. He is an æsthete rather than an apolaust. He delights in whatever lends charm and elegance to life. He takes the same sort of pride and care in his cellar, although he never touches wine, that a scientific floriculturist might take in his greenhouses though their contents never had a place in his drawing-room vases.

Each of the four doctors whose names I have last mentioned discharges distinct social services by bringing the members of various social sections into mutual communication. Politicians, *litterateurs*, artists, actors, journalists, professional men of all grades find themselves in each other's company under the auspices Quain and Clayton, Mackenzie and Thompson. Thus we have a quaternion of doctors who, in addition to the benefits they confer upon humanity by the exercise of the healing art, supply in the plentitude of their amiable thoughtfulness that social cement which causes society's various parts pleasantly to cohere. Such masters of medical science as Sir William Jenner and Sir James Paget constitute a more solemn class in the hierarchy of physicians. The latter is especially in favor with the Whig aristocracy, and the former is much occupied with the Queen.

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### A CIRCULATORY RIOT.

The piles! aha! I knew them well, each feature, though I may not see 'em; old foes, which fume, and fret, and swell, and vex and plague my perineum. You blush at mention of a "pile," and would, perhaps, the theme avoid; well then, suppose, for style, we call the thing a hemorrhoid. Though bearing an ill-omened name, it seemed as if they might not pain us, when first, as visitors, they came and took up lodgings in the anus. But now, at each succeeding bout, the pelvic pains appear distincter, and there can be no longer doubt of their relations with the sphincter. You ask me, by what obvious signs one may with certainty detect 'em. Well, I can only say that mine are like a hornet in the rectum, which, having wandered from the way, and angry at the situation, stings right and left while yet it may, and tortures one in defecation. "Avaunt! it is a vulgar rhyme." Yet stay, there must be means to cure 'em? Oh, yes, if you but



give them time, and meantime patiently endure 'em, there are a thousand cures you know, all certain sure, as dead-shot candy; 'tis well to buy a score or so, and lay them by to have them handy. And when the hornet's rage is spent, and things assume their wonted quiet, the cure—though it may not prevent—will quickly quell the painful riot.—*Canadian Practitioner*.

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### NOTES AND COMMENTS.

Dr. John Murphy, of this city, is making his sixteenth annual visit to Lake Minnetonka. The fish quake when the time for Dr. M's visit arrives.

There have been about fifteen cases of variola in Peoria during the past month. The cases are all mild and no fatal results have yet occurred.

We would call especial attention to the article of Dr. Curtiss in this issue on the Immunity from Disease. His theory is certainly ingenious and well supported.

Dr. Chenoweth's essay on "Man," though lengthy will repay a careful reading, as it is a condensation of the evolution theory, and presents that theory in its clearest light.

The offer of *Hayne's Electro-Therapeutics* and this journal for one year for \$2.50 will be withdrawn after August 15th. Any one wishing that valuable book at a nominal price must send in their cash before that date.

The cholera is spreading rapidly in Spain, about 2,000 new cases being reported daily, with nearly 50 per cent. of deaths. It has also invaded France, and almost any day may herald its arrival in England or the United States.

Say, Doctors! at least a good many of you, you have frequently promised to write for this journal, report a case or something. Now is the time to fulfil your promises. There is no danger that we will let you forget them. Short and to the point.

THE Brooklyn doctors have not withdrawn from the Congress. Why? Because there were only three of them appointed, and that was not enough to kick about. It does seem strange that a city of nearly three quarters of a million inhabitants should have so few appointments.

Genkin in *Wratsch* reports the use of oil of turpentine, in doses of ten drops to a drachm of castor oil, in the treatment of dysentery. There was seldom any disturbance of the urinary organs and the results were better than those obtained by the use of opium.—*N. Y. Med. Journal*.

It is currently rumored in this city that the International Medical Congress and the American Medical Association have been captured by one of the New York schools and will be run under its exclusive patronage. "Madam Rumor" is not always a nunreliable witness.—*Maryland Med. Monthly*.

Dr. N. Senn, of Milwaukee, Wis., has accepted the chair of Principles and Practices of Surgery in the College of Physicians and Surgeons, Chicago, and Dr. C. Fenger takes the chair of Clinical Surgery in the same institution. The College is io be congratulated upon securing such able men for its faculty.

A famous surgeon advises one of his patients to undergo an operation. "Is it very severe?" asks the patient. "Not for the patient," says the doctor: "we put him to sleep; but very hard on the operator." "How so?" "We suffer terribly from anxiety. Just think, it only succeeds once in a hundred times."—*Old Joke*.

Dr. A. M. Duncan, of Hamler, O., reports the case of a retired practitioner suffering from glycosuria, who finds the greatest benefit in the use of buckwheat flour. The sugar almost entirely disappears from the urine, and other symptoms are removed when he uses this kind of flour.—*Canadian Practitioner*.

Dr. N. S. Davis, Jr., Lecturer on Pathology and Pathological Anatomy, will fill the place vacated by the resignation of Professor Fenger. He has just returned from a few months stay in Vienna and Heidelberg, where he devoted his time almost ex-

clusively to the study of morbid anatomy and pathological histology.

The *N. Y. Med. Record* says: "Only twenty-nine physicians of this city, nearly half of whom are connected with the same medical school, occupy official positions in the preliminary organization of the proposed Congress. Philadelphia, with fewer physicians, was given forty-eight positions, and Boston, with one-fourth the number of doctors, was given twenty positions."

The *Canadian Practitioner* complains that several prominent physicians consult with homœopaths. Well, how are you going to help it? Here in Peoria probably half of our regulars meet with homœopaths in consultation, and we believe the same is true in all of our large cities. Talk about ethics! but our observation is that the majority of doctors will go when the almighty dollar leads the way.

A death is reported from a druggist's mistake in putting up grammes of atropia when milligrammes was intended. The prescription was writted 1.5, instead of 0.0015, as it should have been. This comes from fooling with the metric system. Had the prescriber written grains  $\frac{1}{40}$  the mistake could not have occurred. We do not believe in the metric system, and will not give in until we have to.

The Peoria City Council appropriated \$2,500 to prepare for cholera, and from this amount pays three members of the Board of Health \$100 a month each to superintend three inspectors at \$65 per month each. This takes over one-half, and leaves but a small margin wherewith to put the city in a good sanitary condition. But this is about the wisdom of all city councils, and we ought to be thankful for what we get—only we are not.

In the Chicago Medical College, Medical Department of the Northwestern University, Professor E. O. F. Roler has been transferred to the position of Emeritus Professor on account of continued ill health, and Dr. W. J. Jaggard has been appointed Professor of Obstetrics, the duties of which position he had discharged for the last two years with the highest degree of satisfaction on the part of both Faculty and students.

Mr. Ernest Jacob (*British Medical Journal*) has collected all the cases in which death was caused by anesthetics during the year 1884 in England and Scotland. The number of deaths from chloroform was nine: from a mixture of chloroform and ether, two: from methylene, three: from ether, six. In reviewing the cases he says one is struck by the difference in the character of the operations. The deaths from chloroform occurred in comparatively healthy persons; those from ether in persons severely debilitated by disease.—*Louisville Med. News.*

THE Supreme Courts of New York and Massachusetts have settled the matter as to who owns a medical prescription. The substance of the decisions is that the physician in prescribing gives the patient a written order for drugs, and their delivery terminates the operation. The druggist may, on his own responsibility, renew the drugs, for he is a merchant and has a right to sell goods in any shape. He is not bound to give a copy of the prescription, nor even to keep it, though he usually retains it as a protection in case of error on the part of doctors or patients.

Dr. H. C. Wood regards the following as the most efficient sedative cough mixture that he has ever used:

R	Potassi citratis	1 dr.
	Succus limonis,	2 ozs.
	Syrup. ipecac.,	$\frac{1}{2}$ oz.
	Syrup. simplicem, q. s., ad,	6 ozs.

M. Sig.—A tablespoonful from four to six times a day.

When there is much cough or irritability of the bowels he adds paregoric in suitable quantity.—*Med. Age.*

The squabble in New Orleans over the appointment of the various committees of the congress to be held in this country in 1887, was about the most exciting feature of the meeting. It looks to an outsider, like a fight between the "ins and the outs." We believe that the committee appointed last year had full power to do as they have done. Whether they have acted wisely or not in their selections is another question. We hope the new and additional members of the committee will act slowly in re-



vising the work of the old committee. The greatest omission from the list seems to be, that Dr. J. V. Shoemaker is not named; and that the Empire State of Texas has but one representative.

The distribution of officers for the next International Congress does seem a little one-sided. The following analysis of the committee appointing them, is taken from the *Detroit Lancet*. Of 315 officers New York State has 68, New York City 55, Brooklyn has only 2, Philadelphia has 48, Boston 34, Chicago 19, with but 1 from the rest of the state; Washington 19, Cincinnati 13. The United States Army 8, the United States Navy 6, Canada 6, all from Montreal; Charleston, S. C., has 6, St. Louis 6. The states of Iowa, Texas and Minnesota have but 1 each, and quite a number of states and all the territories have no representation at all. The first three cities named have over two-fifths of the entire number, but we suppose more than that proportion of the medical brains of this country is to be found in them. The nominating committee got a severe overhauling at New Orleans, and the "fun" is not over yet. Let the good fight go on, it will furnish many an item yet for the medical editor ere the Congress is over.

The wife of Dr. Frank H. Hamilton, who died on the 4th inst., was of such an unobtrusive disposition that few, even of her most intimate associates, have ever known to what an extent she has aided her husband in his literary and scientific labors. Without special technical training, she yet kept herself familiar not only with her husband's famous cases, but with the literature of the profession, and was his constant adviser and confidant in the preparation of his volumes, as well as his most valuable aid in the work of proof-reading and revising. Not a page of any one of the seven revised editions of his work on "Fractures and Dislocations" (a book of one thousand octavo pages), but had the benefit of her suggestions in the manuscript and her trained eye in the correction of technical, as well as typographical errors; and the same may be said of his "Treatise on Surgery," and "Military Surgery and Hygiene."—*Med. Record*.

The following is from an epitaph on the grave-stone of Mrs. Arabella Greenwood, who died in childhood during the last cen-

ture. It was written by her husband, and evidences alike the depth of his love, his great humility, and his disapproval of the treatment she received:

Such was her condesensione, and such her humilitie,  
Shee chose to take me, a Doctor of Divinitie.

Above all other the Phœnix of her sexe,  
And like that birde one young shee did begette,  
That she might not leave her sex disconsolate.

My griefe for her is verie sore

I can onlie write two lines more:

For this, and everi good woman for her sake,

Never let a blisterre be putte on a lying-in woman's backe.

—*Med. Age.*

### BOOK NOTICES.

A TREATISE ON ASIATIC CHOLERA.—Edited and prepared by EDMUND C. WENDT, M.D., in association with Drs. JOHN C. PETERS, ELY McCLELLAN, JOHN B. HAMILTON, and GEORGE M. STERNBERG. Illustrated with maps and engravings. Cloth, pp. 404. Wm. Wood & Co., New York. 1885.

The subject of Asiatic cholera has received considerable attention during the present year, and the interest has by no means abated. The possible and probable invasion of this country by the plague that is now raging in Spain, gives peculiar interest at this time to everything written upon this subject. The volume before us is the most satisfactory and complete that we have ever seen, comprising as it does chapters on a history of Asiatic cholera. The etiology of cholera. The symptomatology, course, duration, mortality, complications and sequelæ of cholera. The morbid anatomy and pathological histology of cholera. The diagnosis, differential diagnosis, and prognosis of cholera. The prevention of cholera. The prevention of the spread of cholera. Cholera hygiene as applied to military life, and finally the treatment of cholera. These parts of the subject treated by the different gentlemen named, make the work a particularly valuable one, and it should be in the hands of every physician. It forms the May volume of *Wood's Library* for 1885.

POISONS—THEIR EFFECTS AND DETECTION. A manual for the use of analytical chemists and experts. With an introductory essay on the Growth of Modern Toxicology. BY ALEXANDER BLYTH, M. R. C. S. F. C. S., etc. With tables and illustrations. Vol. I. Cloth, 8 vo; pp. 533. Wm. Wood & Co., New York. 1885.

An excellent addition to this popular "Library" series; one that will be of great service to many subscribers, and of usefulness as reference to all. The first chapter, "The Old Poisonlore," is one of great interest and full of curiosities of the history of poisoning.

TRANSACTIONS OF THE MEDICAL SOCIETY OF THE STATE OF TENNESSEE. 1885. 8vo.; paper, pp. 144.

One of the most valuable papers in this volume is that of Dr. D. F. Wright, of Clarksville, "The Therapeutic Effect of the Ligation of Great Arteries," in which he revives the discovery of Dr. H. F. Campbell, which consisted in the tying of the main artery of a member affected with gangrene, erysipelas, or other sequelæ of traumatic inflammation. During the late war Dr. Wright resorted to this procedure in five cases with the happiest results in all.

The procedure is too valuable a one to be forgotten.

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## RECEIPTS.

The date following each name, indicates where the amount credited extends the subscription:

ILLINOIS—Drs. H. Schaefer (2.00), July, 1886; Wm James (2.00), May, 1886; F. C. Vandervort (2.50), May, 1886; J. C. Charles (2.00), May, 1886; Jno. Stout (4.00), May, 1886; D. F. Rupp (2.50), June, 1886; L. P. Walbridge (2.00); May, 1886; H. M. Boldt (2.00), May, 1886.

WISCONSIN—Dr. H. D. Hill (2.00), July, 1885.

TEXAS—Dr. H. H. Darr (2.50) January, 1886.

MINNESOTA—Dr. W. H. Rowe (1.00) January, 1884.

IOWA—Drs. J. D. Elliott (2.00), March, 1886; Thos Garth (.75), May, 1885; L. L. Bond (2.00), February, 1885.

ARIZONA—Dr. J. C. Preston (2.00), June, 1886.

KENTUCKY—Dr. W. N. Bailey (2.00), July, 1886.

MICHIGAN—Dr. A. Garwood, (2.00) June, 1886.

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## ORIGINAL COMMUNICATIONS.

### TYPHO-MALARIAL FEVER.

BY E. L. LARKINS, M. D., TERRE HAUTE, IND.

Read before the Vigo County Medical Society, Terre Haute Ind., Aug. 6, 1885.

This term, first introduced by Dr. Woodward in the *Medical History of the War of the Rebellion*, and since generally adopted by the profession of this country, is used to designate a *form* of typhoid fever which occurs for the most part in the open country, but does not seem to be of common occurrence in the city. When introduced by Dr. Woodward he supposed the anatomical lesions would be found to differ from those in typhoid. Later researches, however, seemed to convince him that he had been mistaken and led him to retract his original observations.

Dr. Hartshorne, in his description of the disease, recognized three morbid elements as causative agents in this form of fever. His experience was confined principally to the Philadelphia Hospital with soldiers brought there from the South during and immediately after the war. These, of course, were broken down physically from the combined influences incidental to armies, and many of them were suffering from the effects of recent or ancient wounds. These causes were malaria, camp or "crowd poison," and dietetic deficiencies which produce scurvy, and give the scorbutic taint to other diseases.

In the malarial form there was more gastric disturbance. An icteroid hue of the skin and tongue, and the remissions were



more distinct. The rose-colored spots, and sudamina, and tympanites were often altogether wanting.

In that form produced by camp or crowd poison the remissions were less marked, a slower onset, more cerebral disturbances and diarrhœa, with epistaxis and bronchitis sometimes, but with both less constantly than in private practice, were predominant symptoms. Deafness less frequent than in civil practice, but other symptoms about the same as in ordinary typhoid fever.

In the third group of cases a peculiar mental and bodily prostration preceded and followed the disease. There was great irritability of the heart, a tendency to mucous hemorrhages, discolorations and petecia, palid large and smooth tongue, and extremely protracted convalescence.

Dr. Woodward found the intestinal ulcers of a different character from those of ordinary typhoid fever. He found the swelling over the glands of Peyer prior to ulceration in typhomalarial fever to rise gradually from the surrounding mucous membrane, and never umbilicated as in typhoid fever, whereas in the latter the tumefaction rises abruptly and has a constricted base.

While the term may not be strictly scientific, it is convenient, and if it does not designate a specific and separate disease, applies with especial force to a distinct form of ordinary typhoid fever.

During the past six years I have observed and treated quite a number of cases of this disease, and in all of them most of the symptoms were different from those of typhoid. While can not say that malarial symptoms predominated—were not in fact prominent factors—but it did seem to me that the destructive characteristic symptoms of true typhoid fever were wanting in many respects.

During the months of August, September and October, '81, I treated in all about thirty-five cases of this disease, two of which proved fatal, one a girl aged about 14 years, who died on the eighteenth day from congestion of the brain, and the other a woman aged about 25 years, who died in the fourth week from abortion. In that year typhoid fever was epidemic in many parts of this country and Europe. Several cases occurred in my practice in the years '79 and '80, and a number since, but in no

one year other than '81 did so many as stated occur. The summer was remarkable, as you all remember, for its early, long continued and excessive heat and dryness.

The town where I then resided is small, containing about 600 or 700 inhabitants. The soil is clay underlaid by a strata of what is known as "hard-pan." This strata occurs in all that country at about a depth of from 15 to 20 feet from the surface. The wells are dug only to the hard-pan, as it is about impossible to dig through it. During the drought many wells failed entirely, and the remainder supplied only a limited amount of water which contained a large amount of organic matter, as shown by the permanganate pot test. The country slopes gradually to the west, and the wells are supplied by veins of water coming in from the east side.

If we consider the town a square, and divided in four equal parts, it will be found that most all the cases occurring there during the epidemic (twenty-seven in number), were confined to the south-west quarter, only one or two cases in the remainder. This quarter of the town contains about one-fourth the inhabitants and is scattered over eight or ten acres of land.

So far as I now recollect there were only two instances where more than one case occurred in a family, and in each of those but two cases. Two deaths occurred in the town from causes above stated. If the poison was taken into the system with the drinking water, it seems to me more cases ought to have occurred in the same families.

So far as could be discovered, the sanitary condition of that part of the town was as good or better than the rest. There were a number of cases scattered throughout the country, but the mortality was light.

The duration of the disease was on an average twenty-three to twenty-seven days. The longest one of my cases was thirty-one days. The shortest eleven days. This does not include relapse or complications which occurred in several cases. I counted the duration of the disease from the time the patient took to the bed until the temperature returned to the normal. All the cases occurred from July to November, inclusive. The youngest in whom the disease occurred was 9 years and the

oldest 52, and so far as sex was concerned were about equally divided.

The disease was usually ushered in by a prodromic stage lasting from one to two weeks. There was slight headache, great muscular weariness, broken rest at night, loss of appetite, bad taste in the mouth in the morning, tongue covered by a white coating which could not be removed by washing, and which I could only compare to the down on a peach. This condition of the tongue was characteristic of the disease. As the disease advanced it would sometimes, for a day or two, change, but would return again. The tip and sides of the tongue were sometimes red, but not so marked as in true typhoid. During this stage there were in the great majority of cases irregular chills followed by slight fever, and night sweats for which symptoms they usually applied for treatment.

After the fever had become continuous there were in many cases great irritability of the stomach, so great indeed in most of them as to seriously interfere with nutrition and medication. This subsided in the course of the first week. In cases of great prostration this often returned in the third or fourth week, and was always a grave symptom, and was best controlled by the free use of the *sparkling wines*, and beef-tea as hot as could be taken. Constipation was present in most cases. Diarrhœa occurred in two or three, which may, perhaps, have been due to a cathartic taken some days before coming under observation.

Instead of pain in the lumbar region often complained of in typhoid there was none, and when complained of at all in the spine, it was referred to the cervical and upper dorsal regions. Pain in the head was not a characteristic or constant symptom. Pain and tenderness in the splenic region was present in most cases, but no constant enlargement of the organ was found.

Tympanites was sometimes present, but in no case was it a symptom of any consequence. The rose-colored spots were never present, but a peculiar flushed condition of the sides of the neck and upper part of the breast was an almost constant symptom during the first two weeks of the disease. Whether the cause of the pain in the cervical region produced disturbance of the sympathetic system there, and the above symptoms a result of such disturbance, I can not say, though certainly they were

associated. Epistaxis occurred in only one or two cases. Delirium was present at night in a few cases, but in all of them after recovery their sickness appeared to them as an indistinct dream.

The temperature, after the fever became continuous, varied from night to morning from one to two degrees, and in no case where no complication existed did it exceed 104. In the majority it averaged about 103½ in the evening and 102 in the morning. In uncomplicated cases the convalescence was rapid.

Quinine had no effect in aborting the disease. Calomel given in 8 or 10 grain doses on alternate days the first week was found to have a good effect, and I was led to believe from its use that it rendered the course of the disease milder. The continued use of the dil. mineral acids, with an occasional change to the oil of turpentine for a few days, especially if the tongue had a tendency to become dry and red, and a sedative dose of quinine on the evening of every second or third day was found in the main to constitute the best line of treatment.

May not the cause of typho-malarial or typhoid fever be due to the same or kindred poison which produces intermittent and remittent fever, in the former producing lesion of substance and in the latter lesion of function, and amenable to the action of quinine in proportion to the extent of such lesion? In intermittent fever the prompt action of quinine is certain; in the remittent form the effect of the drug is not so marked owing to the functional derangements of the stomach, spleen and liver. When these are removed the specific action of quinine is as prompt in the intermittent variety.

Malarial fevers, so called, were very prevalent in this country when people used buckets with which to draw water from the wells, especially from shallow ones, but since the almost universal use of pumps, they are rarely seen. This may in part at least be accounted for on the ground that by the use of buckets water is used from the surface of the well, water which may be impregnated with malaria, and when pumps are used water is taken from the bottom of the well, and free from the poison. That malaria is a poison and not a virus is shown by the fact that one attack does not confer immunity from the disease, but on the other hand the best condition in which to contract the disease is to have had a previous attack. From this it follows that



continuous remittent fever is not of malarial origin, as one attack confers relative immunity from the disease. May not this fever be protective from the typical form of typhoid through some modification of the tissues of the body, as the hybrid, induced disease, vaccina is of that once terrible scourge variola? There are no hard and fast lines in nature, and it may yet be found that those who suffer from continuous remittent fever have typhoid in a modified form.

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### IMMUNITY FROM DISEASE.

BY C. B. MACLAY, A.M. M.D. DELAVAN, ILL.

A writer in the July number of the PEORIA MEDICAL MONTHLY, declares that "there can be no science on the subject of immunity from disease until the law is found which will explain every thing that any man knows on the subject." It is to be feared that we shall have to wait a long time for that discovery. To propose the Darwinian law of natural selection is to offer what Darwin himself confesses, does not explain, without some considerable uncertainty, the theories he proposes, and which have been adopted as true by so many noted scientists. The examples given by the writer alluded to, (maybe, thrown in by way of fun) are not Darwinian.

When a human hand is calloused by "rowing" there is not a true variation of the cells of the integument, and when the doctor ceases rowing the integument does not by atavism return to its former condition. The thickening is a very speedy process and the facts in the case require no astute reasoning to make them readily understood. The variation, if any, and the atavism, if any, can come only in rare cases and at long intervals of time, and that through growth of bone and development of of muscle or the retrograde measure. If the oarsman transmitted his callosities, we should have been long ere this a race of beings with hands cushioned far to exceed the camel's feet in their rotundity. Darwin lays down this declaration to be noted very carefully, to his followers, "*natural selection acts very slowly, and only on a few of the inhabitants of the same region.*" If that is true, it looks decidedly bilious for our new theory of disease. Mr. Darwin further asserts with particular emphasis,

*“Natural selection will soon banish the belief of any sudden or great modification of structure.”*

The writers, lecturers and quasi-scientists who talk about the marvelous changes in structure of the bee, the caterpillar, the musquito and the frog and call these Darwinian developments, reckon without their host, for they enter not into Mr. Darwin's theory at all, and are outside of natural selection. They are, so to speak, in the every day hum-drum round of animal metamorphosis from which there must be variation to give a chance for natural selection to play its part. If on the contrary these departures were rapid or declared to be rapid, then we might expect to find many forms in actual transition; but really one theory is as good as another since Mr. Darwin takes his fundamental basis for granted, and all other theorists may do the same. It is then a question of probabilities, and in its very essence unscientific. No half-way developed animals are found on the earth alive, nor are any such found in the rocks. Moses is said to have made mistakes, but so far science is with him, “and God saw every thing that he had made, and behold it was very good.”

The writer referred to above certainly has taken up an erroneous idea in regard to the law of natural selection. He says, “So the wolf chases the antelope, if happily he may catch him. This is called natural selection. The wolf selects the antelope for the reason that he can't select anything else.”

This may be a natural selection but it is not the natural selection that has made Darwin famous. Neither does this give “the whole story of natural selection, atavism and transmission by hereditary descent, and the sequent survival, immunity and atavism.” Scientific phrases have a lovely captivating sound, but often they are sounding brass. Darwin teaches that nature selects from the mass of beings those best fitted for the spheres they occupy, and by very small variations the fittest that survive the physical changes are adapted to new circumstances, and thus in all nature there is an onward and upward march toward perfection. The selection that a flea makes of a tender skin, the choice that a louse makes of a dirty scalp, and the bedding that the microbe secures in the corner of the lungs or bowels, have no relation whatever to Darwin's famous law, except in so far as the most mature and efficient operative is supposed to “win his

spurs," or to receive higher endowment on account of his effective action. According to Darwin's law the microbe showing the greatest pertinacity and the supremest fitness for the work done, may in a thousand generations receive from nature new and especial endowments. The fight between the tissue cell and the microbe, if fight there be, is of no more scientific relation to the new philosophy than a dog bite. Giving a title to an essay does not go far in explanation, and bestowing a sonorous term on a disease does not explain anything.

From a consideration of the numberless varieties of temperament, the constitute peculiarities of tissue, and the continuously modified fluids of the system, it should not be very hard to understand the subjection to or immunity from a great many forms of disease. Whether the *matrices morbi* is chemical in its relations, or whether it is a living cell is a matter of some scientific interest, but the tolerance of resistance to, or the complete overthrow of the vital powers by it, may be at least partially understood by considering analogies which are evident on all sides. Any physician of experience could give a very good guess as to what persons would be most likely to be affected by different kinds of weather; by warm or cold seasons; by dry or wet extremes; by times of great excitement or extreme quiet; by success or failure in business. When certain diseases are rampant, we fear for the constitutions of certain persons because we know they are peculiarly endowed. Give the color of skin, hair, eyes, the chest, abdominal and head measurements, their place of birth, sex, residence and occupation, and a little of their personal history and it is not hard to forecast their morbid future.

That great changes occur in tissues is certainly true. Climate, age, food and occupation may each materially alter physical peculiarities, and it is not to be wondered at that continued exposure to destructive agencies, while at the same time the vital energies are sustained, may result in such changes of tissues as to secure entire immunity. When the exposure ceases it is not unreasonable to believe that the tissues will return to their normal condition. By what process? The law of adaptation, or if you will by the old philosophy, "the eternal fitness of things."

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## CASE OF ICHTHYOSIS.

BY F. C. VANDERVORT, M. D., TONICA, ILL.

I reported a genuine case of this affection in the *PEORIA MONTHLY*, Vol. II. No. 6, and gave a description of the disease. The first case was lost sight of for nearly three years, but has turned up once more, the scales having fallen from his eyes, but not from his head, neck and trunk. When the family returned from the west, they had not one but two scaly boys. The second is now nearly three years old, and looking at his back reminds you of seal skin without any fur. The boys are both stout, bright, healthy lads and are never sick. August is their worst month, for the heavy brown scales prevent transpiration. Later on they will peel off and appear as fresh as locusts just emerged from their cast off shells. This process of scaling and peeling goes constantly on.

July 20th the mother of these two boys was delivered of a third child by myself. It was a girl, but alas, ere it had breathed the breath of life five minutes, its skin began to dry and crinkle, and feel very much like parchment. The child is now about a week old and is scaling off for the first time. It is very humiliating to the parents to have such children, and it is with great reluctance they give up the curability of the disease. When the first child was born, I cautioned them against wasting time and money trying new doctors for relief. They felt they could not give up and have tried many physicians and some of high reputation.

Nothing but cleanliness and "extreme unction" has done any good. I have never been able to find any clew to the cause of the disease in those children until just lately, and perhaps in the minds of many, none yet.

The mother showed me a vaccination scar upon the right arm over the deltoid muscle. She said it was a vaccination scar, but it had not the slightest resemblance to one. It is a tumor in the skin, of deep red color, raised up, and about the size of a man's middle finger. It is rather hard and tender to the touch. She was inoculated in St. Louis when she was five years old, which was many years ago when humanized virus was mostly used. My theory is, she was inoculated with the lymph from



some person having a skin disease; it might have been ichthyosis, eczema, or psoriasis, it matter not.

It has affected her system just sufficiently for her offspring to inherit it, but not enough for her to develop the disease in herself. It is impossible, from all knowledge of the cases for there being present any syphilitic taint. Remedies for such have never produced any effect upon the disease. I believe such cases are very rare, and I report them for the same reason I would report a freak of nature.

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## CUTANEOUS POISONING WITH RHUS TOXICODENDRON.

BY W. H. TATE, M. D., GREENSBURG, OHIO.

Rhus Toxicodendron is a very common shrub in this country, and well known by its property of inflaming the skin to a very alarming extent, simply on coming in contact with its leaves, or by a close approach to it, in persons who are particularly sensible to its influence. When touched or handled, it produces in the course of two or three days very serious symptoms.

The skin inflames and swells, being attended with a very distressing burning pain. In severe cases, if the face be affected, the eyelids are so tumefied as to close up the eyes; the whole head is sometimes swollen and covered with little blisters containing serum. Sometimes the whole body is enormously swollen and covered with serous vesicles. When the inflammation and swelling have in some degree subsided, the epidermis begins to separate in little squamæ, and an intolerable itching is felt for some days longer. The arterial system during an affection of this kind is very considerably excited. These symptoms bear a very strong resemblance to erysipelas; and it has been observed by some of the writers on dermatology, that they yield to the remedies commonly employed for the cure of this latter affection.

Aqua ammonia, diluted with water is a useful application, and an aqueous solution of corrosive sublimate has also been recommended; but recently I attended an extreme case which did not seem to yield to any of the popular remedies commonly rec-

commended for such cases. I used a drug which I had never before applied for affections of this kind, although it may have been prescribed by others, viz: Sulphate of copper in the following manner:

R. Cupri Sulph.	2 drs.
Aqua	8 ozs.

Dissolved.

Sig.—Apply to the surface of the body with a piece of sponge or soft linen three times a day.

After one or two applications of this preparation, the pain and burning begin to subside, and in a few days all of the alarming symptoms disappear. I have since used the same preparation on similar cases with good results.

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## ECLAMPSIA CAUSED BY PHIMOSIS—OPERATION—RECOVERY.

BY FRANK L. HINSDALE, M. D., TOLEDO, IOWA.

On July 20th, 1885, G. McC., five years of age, was brought to my office and the following history given: When eighteen months of age he had scarlet fever, and since that time had had convulsions. Some six months ago he had measles, and since that time the convulsions had been more frequent and severe. He had been treated by several physicians in the three and a half years that he had been afflicted, but had steadily grown worse, and was then having from twelve to fifteen convulsions a day.

The convulsions were always preceded by premonitory symptoms, and the pain was always referred to the teeth. While I was examining him he cried out "My teeth hurt." His mother said, "He will have a convulsion now." In a moment he was writhing in a clonic convulsion. The muscles of the left side were principally affected. The mouth was drawn out of shape by the muscular action. The teeth were firmly pressed together. The eyelids were open and the eyes were turned so that the

pupils were hidden beneath the upper lid. The arm, fingers and thumbs were fixed. The thumbs were drawn across the palms of the hands. The leg was also forcibly flexed. The duration of this attack was about five minutes. His mother said that the attacks usually lasted about that long, but occasionally longer.

His mother also informed me that there had been some trouble in micturition for quite a length of time. She thought for a year or possibly longer that he had complained of pain while urinating. I noticed that during the convulsion he tugged at his penis with his right hand, and this together with the mother's statement that he had had some trouble during micturition led me to examine carefully that organ.

I found upon examination that the prepuce was very tight and internally adhered to the glans penis, in fact, it was so tightly adhered that it could not be drawn over the glans.

I could find no other cause for the eclampsia than the phimosis. He was as bright and intelligent as boys of that age. No history of any mental or nervous disease in the family, although his mother is of the "nervous temperament."

My opinion was that the phimosis dated from the attack of scarlet fever and that it must have been caused by the inflammation of the mucous surfaces followed by adhesion of the two surfaces. I advised an operation and told the mother that I believed the phimosis was the cause of the convulsions. I operated the next day, removed a portion of the redundant prepuce and separated the glans from the prepuce. In the cervix behind the corona glandis there was collected a quantity of ill smelling sebaceous matter. This was removed and the parts thoroughly cleansed and dressed. In ten days the parts had entirely healed. The afternoon of the day of operation the boy had one convulsion and since that time has had none, while before the operation he was having twelve to fifteen convulsions each day and was quite weak and emaciated. He is growing stout and gaining flesh rapidly. It is the only case of the kind that I have ever seen and don't remember to have ever read an account of a case similar to this.

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## SOCIETY TRANSACTIONS.

## CHICAGO MEDICAL SOCIETY.

ASPERGILLUS GLAUCUS FROM THE EAR—OSTEOMA—MYCELIA FROM  
A TONSIL—TREATMENT OF ACUTE CORYZA.

*Stated Meeting, July 6, 1885.*—The First Vice-President, C. W. Purdy, M. D., in the chair.

Dr. Robert Tilley exhibited to the society microscopical specimens of the fungus, *aspergillus glaucus*, taken from the human ear, an osteoma developed from the crista petrosa of a canine tooth, and filaments, or mycelia, from the body of a tonsil.

While exhibiting the specimens, Dr. Tilly spoke as follows:

In describing to you the three specimens which are exhibited under the microscope, I will refer in the first place to the fungus—*aspergillus glaucus*—taken from the human ear. I have had this in my possession for about three years and have shown it to several of my acquaintances, but did not deem it of sufficient interest to exhibit before. It is however an object which many have not been seen before, although it is mentioned in every text-book on the subject. I have no intention whatever of entering into the question of the *aspergilli* in general relative to their influence when found in the ear. But I must say that my experience relative to the question leads me to think that its influence as a source of pain in the external ear is greatly exaggerated in the books. This specimen was taken from the posterior wall of the meatus of a little girl who had for some time previously been afflicted with otorrhœa. The otorrhœa had, however, ceased, and the fungi were readily recognized in lusty growth immediately on looking into the ear. There was, however, no pain complained of, the patient was brought rather for inspection than for the expectation of relief. You will observe that the fungus consists of one straight long stem surmounted by a round ball, very much like the top of an onion which has run to seed. It is commonly said, I think rather on theory than on observation, that they are caused by sleeping in low, damp apartments. The child from whom this was taken belonged to people in good circumstances and was well taken care of and was not living in damp quarters.



The next specimen, to which I will now refer, is the osteoma developed from the cementum or crusta petrosa of a canine tooth. I am very sorry that I cannot give you anything of the clinical history, because I believe it would be interesting, if known. In consequence of this, it is perhaps necessary that I should give a word of explanation as to how it came into my hands: A friend was speaking to me of some one who had been subjected to the operation of drilling through the fangs of six teeth on account of what was called "ossification of the nerve." In speaking to one of my acquaintances among the dentists about such a condition, I was presented with a tooth a section of which I exhibit to you. You will see, both macroscopically as well as microscopically, that the line of demarcation is well defined. You will further see that the general appearance of the tumor is that of bone, and that it differs greatly from the general appearance of the tooth proper. It is interesting to observe moreover that the canal, through which the nerve and vessel enter, is greatly diminished in its course through the tumor, consequently great pressure must have been exerted on the nerve. Before making the section, I had supposed that the canal was completely obliterated, so small is its opening at the end of the tumor. On looking at the specimen through the microscope, you will see very clearly that while the line of demarcation between the dentine and the dentine proliferation of the crusta petrosa is well marked, and the lacunæ and canaliculæ of the bony structure of the tumor are well demonstrated, there are also a number of contorted tubules in the bony tumor which resemble, somewhat, the dental tubules. Haversian canals are of course not present, they never are in such growths.

Although I have no clinical history to present, I may add that the usual clinical history is one of severe pain, which nothing but extraction seems capable of relieving. The last specimen is one which I obtained from one of those little pockets which are often found in the tonsils. They seem to come and go, sometimes without giving any more inconvenience than a little discomfort. They are frequently associated with fœtid breath, and in some cases the masses themselves are very offensive (in odor). In the present case, however, this was not so, there was no factor. There was, however, an unpleasant sensa-

tion amounting to a positive discomfort running down the neck externally, in the direction of the sterno-cleido-mastoid (muscle). On pressure around the base, the little mass popped out, suddenly, so that it came near going down the patient's throat. In examining it, under the microscope, it proved to be one mass of filaments, very fine and containing spores in the body of the filaments, and associated with fat crystals.

I succeeded in staining them with methyl violet, but only after first extracting the fat with ether.

I have no theory to present, gentlemen; I simply exhibit to you what has been interesting to me. After the removal of the small mass I did not think any treatment was necessary, but as there was a little bridge of tissue more or less dividing the cavity into two sections, I divided the bridge with the electro-cautery.

*The Treatment of Acute Coryza*, was the subject of a paper by Dr. J. A. Robinson,. He said the literature on the subject of the treatment of acute coryza is scanty and of a stereotyped nature. The profession seems to have arrived at two conclusions, first, that it is not a disease of sufficient severity and importance to command especial attention; second, that no plan of abortive or curative treatment has been sufficiently successful to cause them to investigate the subject further. However, in view of the fact that repeated attacks of acute coryza undoubtedly have a causal relation to pathological changes in the nares which it is difficult to remove, and that we are so frequently consulted by public speakers and singers who beseech us to abort or rapidly cure such acute attacks, it certainly deserves more than a passing notice.

The time-honored plan of aborting an acute coryza by the administration of a full dose of opium, an active purge and a potent diaphoretic has proven more disagreeable than efficacious. The plan, advocated by Dr. Ferrier, of blowing into the anterior nares a powder composed of morphia, bismuth and acacia, has been quite satisfactory in a few instances, but it is not free from the objection that, when successful, it often produces an unpleasant nausea. Its success is undoubtedly due to the sedative and astringent effect upon the inflamed mucous membrane.

What are the pathological conditions in the first stage of acute coryza? Briefly, there is dilatation of the capillary vessels,

the arterioles being dilated and the venules engorged, inducing tumefaction of the mucous membrane. This is accompanied by dryness and pain. Secretion is abolished. In reflecting upon these circumstances the thought naturally arises, whether, if we can employ such measures and drugs as will antagonize these abnormal states, we will succeed in aborting the disease. We have recently had added to our armamentarium a drug which more completely antagonizes in its physiological actions these pathological conditions than any other. It is the hydrochlorate of cocaine.

Its physiological actions have been demonstrated to be concisely as follows: when applied to a mucous membrane it is a potent although transient anæsthetic, a vaso-motor constrictor causing contraction of the arterioles and depletion of the venules, thus rapidly emptying congested tissues of a surplus of blood. This drug is also an astringent and has the property of lessening the secretion of muciparous glands. On studying the relation between the state of the nasal mucous membrane in the first stage of acute inflammation and after an application of cocaine, the theory was formulated that cocaine should prove useful in aborting acute coryza, and it was determined to try it on the first opportunity. The details of the experiment are as follows:

Miss S——, a soprano singer in one of our city churches, applied to me on the morning of February 22d, and desired immediate relief from a "cold in the head." She complained that the previous night she had been exposed to a draft and awoke that morning with a cold, as evinced by the fact that she could not breathe through the nose, and that her nose felt dry and painful, and she had lost the sense of smell. Inasmuch as she had to sing that night at a special service, she must have immediate relief.

Upon examination I found all the conditions incident to the incipency of an acute coryza. Her temperature was 102 F. with some acceleration of the pulse.

Febrifuges and a mild diaphoretic were prescribed. A local application of a four per cent. solution of hydrochlorate of cocaine was applied, as thoroughly as possible, to the congested mucous membrane, and the parts were sprayed, also, for some time with a warm alkaline spray, hoping thereby to reduce the hyperæmia.

After having made another application of the cocaine, the patient was instructed to return home and follow the same line of treatment and to return the following day. She did not return until three days later, when she reported, to my surprise and gratification, that she had been able to sing as desired, and that no symptoms of the disease had returned.

The success which attended this new departure, induced me to try it in other cases of acute coryza which were seen early, and it has almost always been successful. Of course, the number of cases which we see in their forming stage are few, on account of the fact that the patients do not seek medical advice for this affection until the disease is well advanced.

In the use of cocaine for the purpose of aborting an acute coryza there are some objections: it has to be applied often in order to maintain its action on the inflamed mucous membrane, and it is an expensive drug. I have found that the use of a warm alkaline spray serves to prolong the sedative action of the cocaine.

Of course dependence is not to be placed on local measures alone, but in addition proper attention is to be given to constitutional and hygienic treatment.

Dr. Tilley said he had used the hydrochlorate of cocaine in two or three cases of acute coryza with much satisfaction. According to one patient, an attack had ended with a single application. While he did not look upon cocaine as a sure cure for acute coryza, he thought it almost always did good. He referred to a serious accident which occurred to one of his patients during the use of cocaine. The patient was a boy aged twelve years, in whose nose a little cocaine had been used. After the first application he suffered a little nausea, which was not regarded as serious; after the second application the nausea was worse, but it was not until a third application had been made that the symptoms became alarming. These symptoms were difficulty of breathing, syncope, irregular action of the heart, cold perspiration and loss of sensation in the extremities. Notwithstanding these symptoms were alarming, the boy recovered quite rapidly. He had noticed reports of cases in the papers where the same symptoms had appeared.



Dr. Weller said that he had had a good deal of experience in the use of coca, especially in the form of the fluid extract. He had taken large doses, in his own case he had used two pounds in a short time. Formerly he had considered it as harmless as tea, but latterly he had arrived at the conclusion that it is a powerful narcotic. The strange phenomena which follow use of cocaine in some cases, he believes to be due to the narcotic action of the drug, and that they would not appear if the drug was not given in large doses. He believed some patients to be peculiarly susceptible to the action of coca or cocaine, similar to the idiosyncracies of patients in the use of belladonna, opium and alcohol. In the case mentioned, he believed the symptoms to have been the result of an over dose of cocaine. In his experience, he had found a two per cent. solution of cocaine strong enough, and urged the tentative use of the drug in the same manner as in the use of morphia.

Dr. Webster did not wish to be considered skeptical, but he had some doubt as to the alarming symptoms in the cases mentioned having been due to the drug. Is it not possible they were the result of reflex processes in over-sensitive patients? He had a patient recently who vomited after holding a fever thermometer under her tongue.

Dr. Paoli believed that the old treatment of acute coryza by giving the patient a hot bath, muriate of ammonia internally, and inhalations of camphor in hot water, or the oil of eucalyptus, combined with borax, to be the best, although he would acknowledge that cocaine would often relieve severe attacks in a short time.

Dr. S. J. Jones asked the author of the paper if he had used cocaine with a steam atomizer in acute pharyngitis, tonsilitis and laryngitis; also, if the applications of cocaine to different patients were from the same solutions and at brief intervals, so as to be able to state how a reliable solution acted on different patients.

Dr. Robinson, in closing the discussion, said he did not advocate the plan of treatment as infallible or free from objections, nor did he neglect to use other means of cure if he thought they were advisable. As to the effect of cocaine on certain patients, he had a similar experience to Dr. Tilley in the case of a woman who had twice been operated on without cocaine for nasal polyps.

No unfavorable symptoms occurred during these operations. At the third and fourth operations, cocaine was used and the patient was troubled with nausea, vomiting, palpitation of the heart and syncope. He had not used cocaine with the steam atomizer, but he thought it feasible, if the drug were not so expensive. He prepares fresh solutions for each patient so as to preclude all possibility of failure of action by reason of deterioration of the solution by age. He had found the same package of cocaine to vary in its local and constitutional effect on different patients, affecting some more rapidly and profoundly than others.

Society then adjourned.

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#### MEMBRANOUS OCCLUSION OF POSTERIOR NARES.

*Stated Meeting, July 20, 1885, S. J. JONES, Chairman, pro tem.*

Dr. W. E. Casselberry read an interesting paper detailing the surgical procedures in a case of membranous occlusion of the posterior nares. His patient was aged about fifty, a native of Russian Poland, and had suffered from obstruction of the left nasal chamber for the last thirteen years. Thick, viscid and foul muco-purulent crusts accumulated in the nares and nasopharyngeal space which he could neither expectorate nor expel through the nose on account of the impenetrability of the nostril to currents of air. Partial occlusion, also, of the right nasal chamber necessitated frequent and prolonged mouth-breathing, and consequently he has suffered from atrophic pharyngitis and laryngitis, with painful deglutition, cough, suffocative paroxysms, etc. Deafness in the left ear and annoying *tinnitus aurium* have long been prominent symptoms. Most violent paroxysmal headaches, constant soreness on the top of the head, vertigo, especially upon stooping, and various indescribable cephalic sensations of a most distressing character, have served to render life miserable.

By a rhinoscopic examination the pharynx was seen to be covered with a foul, viscid, muco-purulent substance, continuous in descent from the naso-pharyngeal space, and imparting to the expired air a disgustingly fetid odor. The naso-pharynx was filled with rotton crusts which necessitated removal for further

inspection of the part. Having thoroughly cleansed the parts and accustomed the patient to instrumental manipulation, by using Voltolini's uvula holder, a good rhinoscopic image was obtained. All previous efforts to pass a probe from in front had failed, and passing the finger behind the palate through the mouth, an obstruction was encountered. The rhinoscopic image revealed a tense membrane covering the left choana almost completely. Its free edge was thin and sharp and approached so near to the septum, that only a small slit or opening remained between it and the septum narium. The left ostium tubae could not be seen, the membrane evidently lying behind the Eustachian orifice, and so intercepting its image. On passing a probe between the membrane and septum the edge of the membrane could be pushed backward. It felt tense and was from one to two millimeters in thickness.

The right choana was partially covered by a membrane extending half across the aperture and intercepting the view of the superior and outer half of the middle turbinated bodies, and the right ostium tubæ. This membrane was much thicker and less tense than that on the left side.

In order to prepare the patient for treatment, he was trained daily for one week in the introduction of mirrors and instruments. A flexible silver probe was bent, after many trials, to exactly the proper curve to pass readily by way of the mouth and naso-pharynx into the opening on the left side and to pick up the membrane. A straight knife electrode was then made to conform to the same curve, and lastly this instrument, with the attachments complete, made several trial trips to the desired locality. All being in readiness, December 13, 1884, the knife-electrode was introduced through the opening between the membrane and septum and its edge pressed backwards against the membrane. At this moment the patient retracted the soft palate and shut off all vision. But, thanks to previous training when instructed to relax all the parts the velum fell and the rhinoscopic image was perfect. Having adjusted the electrode properly the current was turned on, the knife end became red hot in an instant and the membrae was incised without bleeding, and without sufficient pain to cause the patient to wince. In another instant the current was broken, the electrode cooled in a

few seconds and was withdrawn. An examination revealed that the work had been wonderfully efficient. The membrane having been tense, when it was incised, each part retracted leaving an opening sufficiently large to bring into view the middle and inferior tubinated bodies, and to the delight of the patient to allow a free passage of air through the left nostril, and from that moment he has had none of the distressing cephalic symptoms mentioned. The floor of the nose, the septum and the tubinated bodies were thickly incrustated with horribly fetid, cheesy masses, decomposed and dessicated secretions accumulated for years, which were removed with great difficulty. The catarrhal symptoms then gradually became less distressing. After two similar operations the left ostium tubæ became visible in the rhinoscopic mirror, and two or three touches with the knife served to entirely obliterate the membrane. Four similar operations served to obliterate the membrane in the right side, and now both posterior nares are widely patent and in an approximately natural condition.

It is probable that atresia of the posterior nares is by no means so rare as the few reported cases and the omission of all mention in many treatises might lead us to suppose. The reporter had seen reports of two cases only occurring in the adult, one by Voltolini and another by Pomeroy. Records of cases occurring in infancy are more common, doubtless because the nursing function necessitates either a correct diagnosis and operation for relief, or death ensues and an opportunity for a *post mortem* examination. Reports of such cases are recorded by Ronaldson, Luschka, Betts, Cohen and Emmerts. In all these cases the malformation was congenital and it was probably so in the case above reported. This patient has never suffered from any illness which would act as a cause for the development of such a membrane. It may be possible that in earlier years the membrane was relaxed and less complete, similar to the condition found on the right side, and later it underwent contraction, became thinner, more tense and sufficiently extended to cover the choana. The left membrane was composed chiefly of a reduplication of mucous membrane, with possibly some connective tissue and muscular fibres interlying in the thicker portion toward the outer border. The right structure contained considerable muscular



tissue. There was no osseous malformation. Upon the left, the attachments were, apparently, to the mucous lining of the superior posterior edge of the vomer, the inferior surface of the body of the sphenoid bone, the left pharyngeal wall behind the Eustachian orifice and the superior posterior surface of the palati. Upon the right the attachments included only the inferior surface of the body of the sphenoid, and the right pharyngeal wall behind the Eustachian orifice.

The galvano-cautery is more useful in such operations because it is a dull instrument: can be introduced or withdrawn without harm: can be used when applied to the proper place, and almost no bleeding or pain ensues.

The Society adjourned immediately after the paper was read and Dr. Casselberry had exhibited a Fleming galvano-cautery battery with electrodes—as modified by Carl Seiler.

OLEATE OF MANGANESE—DOES THE USE OF TOBACCO INJURE SIGHT?—LACERATION OF THE CERVIX UTERI.

*Stated Meeting, August 3, 1885.*—President Charles T. Parkes, M. D., in the chair.

Dr. Franklin H. Martin read a paper on the “Oleate of Manganese.” He said: There is little doubt left in the minds of therapeutists in regard to the value of manganese as a remedy in certain forms of menstrual trouble. The remedy, in the form of permanganate of potash, was first brought to the attention of the profession by Ringer and Murrell, of London, in the spring of 1883. They recommended the drug in functional amenorrhœa. Soon after this he commenced experiments with the same preparations, and published the results in *The New York Medical Record*, September 29, 1883. To his knowledge, that was the first that anything on the subject was published in this country.

In the course of his experiments, acting on the theory that the drug produced menstruation by stimulating the menstrual organs, he was induced to give the remedy in menorrhagia and metrorrhagia dependent upon an *atonic* condition of the organ. He found to his gratification that it acted equally well in these conditions, as in the opposite. He also has obtained good results from its

administration in irregularities incident to approaching menses. He has received very gratifying letters from many members of the profession throughout the country, who have used the drug in one or more of the conditions mentioned above, with good results.

Dr. Thomas, of New York, says of the remedy: "I think it is the best emenagogue which has yet been discovered."

Dr. Roberts Bartholow not only recognizes its power as a remedial agent in amenorrhœa, but also considers it a general stimulant, making it equally efficacious in other menstrual difficulties dependant upon an *atonic* condition.

After publishing his second report on this subject, the author received a letter from Sidney Ringer, of London, in which he expressed his gratification at the result of his experiments, and in which he said:

"Like you, I have found the permanganate most useful in atonic conditions," and further remarked, "I was quite prepared to learn that the permanganate is useful in menorrhagia."

Since there is no longer any doubt about the great value of this drug in the distressing menstrual difficulties, the next formidable problem for the therapist to solve is, How shall it be administered? The permanganate of potash, the original preparation used for experiments and administration, in any form is liable to act as an irritant to the stomach. It has in many ingenious ways been made into pills, but as these pills must from necessity have for their basis kaolin, or some other inorganic substance, the drug in this form is not satisfactorily absorbed. The compound tablets of Wyeth & Brothers, and other druggists, are objectionable, in many cases of irritable stomach, because the irritating undiluted drug comes in direct contact with its mucous membrane. On account of the many difficulties of administration, therefore, this valuable remedy has not met with the reception that is its due. Following the suggestion of Dr. Lewis L. McArthur, of this city, he succeeded in having an oleate of manganese prepared. This oleate was made for him by Edward Kreyssler, of the firm of Forsyth & Schmidt, of Chicago. He says he is indebted to Mr. Kreyssler for the following statement of the *mode of preparation and of the physical and chemical properties of the oleate of manganese*: A solution of sulphate of man-

ganese was made in distilled water and to it a solution of sodium oleate was added. On mixing these two solutions gradually, and with constant stirring, a precipitate of oleate of manganese resulted. This precipitate, upon heating, changed to a putty-like mass. This was washed several times with warm distilled water, to remove the sodium sulphate, and the resulting mass was the pure oleate of manganese. It is a light-gray color, having a pinkish hue, of a sweet musty taste and peculiar clay-like odor. It is sparingly soluble in alcohol, soluble in ether, chloroform, olive oil and oleic acid.

*The Method of Application.*—He recommends that one drachm of twenty per cent. solution of the oleate of manganese in oleic acid be applied to the abdomen of the patient, and its absorption promoted by friction of the hand.

In amenorrhœa it should be applied, if possible, every night for a week preceding the expected menstrual period, or at the time menstruation is due, and until it makes its appearance. In menorrhagia or metrorrhagia it should be applied in smaller quantities, every night, until the desired effect is produced.

Of about a dozen cases in which the oleate has been prescribed by him, but four had reported. The success in these four was all that could be wished. Three of the four were cases of *atonic amenorrhœa*, the fourth, irregularity due to approaching menopause.

In the discussion, Dr. Etheridge thought much advance would be made in the use of drugs if we were more careful to discover in what conditions they were beneficial. He had found this remedy useful in cases of atonic amenorrhœa, with the uterus in its normal position. He had found the aqueous solution an eligible preparation, and had also used it in the form of a suppository.

Dr. E. J. Doering said he had used this remedy in some cases of atonic amenorrhœa with good results. He asked the effect of the drug upon the pregnant uterus.

Dr. Paoli had used manganese somewhat for several years, in cases of menstrual disorder, with varying degrees of success. It was a useful remedy in many skin diseases. He had not used the oleate, and could not see how it acted upon the uterus, unless, possibly, by being applied at once after being freshly prepared.

Dr. Martin closed the discussion by saying he had used the aqueous solution in very small doses, also had had the remedy put in dry powders and swallowed with a glass of water. He had never used it in the form of a suppository. Manganese has no effect on the pregnant uterus. The drug seems to act as a general stimulant to the uterus, causing it to perform its normal function. It might be absorbed as the oleate and so produce its effects.

"*Does the Use of Tobacco Injure Sight?*" was the subject of a paper read by W. Franklin Coleman, M. D. The question was answered affirmatively by the author.

In the discussion, Dr. Paoli said while the excessive indulgence in tobacco might be harmful, the fact of its almost universal use and continued use in many cases for years resulted in no deleterious effects, would seem to show that its narcotic power, used in the ordinary way, was very slight. He had used tobacco for fifty-five years and felt no ill results. The Germans use large quantities of it, and do not suffer. This seems to be a case of excess of zeal on the part of the ophthalmologists to discover a cause for amaurosis. We ought to be conservative on this point.

Dr. Coleman closed by saying that only in certain susceptible conditions was tobacco liable to cause disorders of vision. But that so few suffered was no proof that it had not this baneful influence when acting with other causes.

*Laceration of the Cervix Uteri.*—Dr. John Bartlett read a paper in which he said his object in addressing the Society was to suggest a way and a time in which laceration of the cervix uteri may be easily and certainly detected soon after its occurrence.

Directly after delivery, if the fingers be introduced deeply into the vagina up to the contracted os uteri internum, and then carried in any direction a little outwardly, the flabby and floating ring formed by the non-contracted cervix may be felt, as Guillemeau described it three hundred years ago, "like a section of large intestine."

By very carefully following the entire circumference of this ring an existing rent may be discovered. But this examination is attended with some difficulties. The patient is exhausted with her labour, fatigued with attentions, and just now, since "it is all



over," longing for rest. She is impatient of, and perturbed, by the *post factum* inquiry. Her state of mind, and possible expression of complaint, are apt to render an examination, which the physician cannot regard as absolutely necessary, less exact and thorough than it would be otherwise. And then, the soft and floating margins of the cervix have often somewhat of an intangible feel, if the expression be permitted, gliding past the fingers like a detached clot of blood, and occasionally, in some portion of their circumference, passing out of satisfactory reach.

On this account it is not surprising to hear an obstetrician say that he cannot tell whether the post-partum cervix is lacerated or not. The error of the accoucheurs who fail to recognize such a condition is, that they do not make their observation of the suspected cervix at the proper time. They examine the neck actually, as has just been done mentally—after the clearance of the uterus. The favorable moment for the examination—and that he said was the special point of his remarks—is just as the placenta is beginning to occupy and distend the cervix. The collar of flesh is then not floating and uncertain in feel, but stretched and expanded, forming a distinct ring, easily followed in its entire circumference. At this moment then, just as the cervical tube is being rendered tense by the placental mass, any laceration in it may be detected with ease and certainty.

Dr. Etheridge asked the author of the paper whether he had verified a case by speculum examination after discovering it in the way he had in his remarks.

Dr. Parkes said he had great difficulty in detecting laceration after delivery, on account of the relaxed condition of the parts. He thought the suggestion of Dr. Bartlett as to the way to obviate this difficulty was a good one.

Dr. Doering inquired as to the size of lacerations he had found.

Dr. Bartlett concluded by saying that he had verified cases of laceration discovered in the manner proposed by him. The largest laceration he had found was one and a half inches in length, and the end of the little finger could be passed into it. In one case he encountered considerable hemorrhage from such a

rent, and this may be the cause of continuous loss of blood when the os is well contracted.

Dr. Bartlett illustrated his remarks with earthenware models, turned by a potter, under his immediate direction.

Society then adjourned.

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## PERISCOPE AND ABSTRACT.

### SURGERY OF THE SPINAL CORD.

Dr. J. Campbell thus writes in the *Canada Lancet*, May 1885: The very interesting and important subject of what now generally goes by the name of "Railway Spine," has during the past year been attracting renewed interest. This has been owing in a great measure to the publication of Page's work "On the Injuries of the Spine and the Spinal Cord." Mr. Page has been for a number of years surgeon to one of the greatest railway corporations in England, and, therefore, had a very extended experience of all possible railway injuries, and particularly of cases of so-called "Railway Spine." He contends that cases of what are commonly called "concussion of the spine," do not exist, except in the imagination of the surgeon making the diagnosis. By concussion, he means the cord receiving an injury of such a nature as to give rise to pronounced symptoms, without, at the same time, the vertebræ, ligaments or membranes receiving any hurt.

It is well known that Mr. Erichsen has been a strenuous advocate of the theory that the great majority of cases of railway injuries having for their symptoms spinal symptoms, are due to concussion of the spinal cord. The first one hundred pages of Mr. Page's book are taken up with combating this view of Erichsen, and it appears to me that Mr. Page's attempt has been successful. He, at least, conclusively shows that the vast majority of cases of concussion of the spine are nothing more nor less than cases where the lumbar muscles or ligaments of the spine have been sprained or ruptured. Erichsen contends that many cases of "concussion of the spine" received in railway accidents, never recover, while Page, on the other hand, maintains that these cases of so-called spinal concussion always do recover. While representing the reaction, Mr. Page's recent work certainly favors a due belief in the certainty of recovery of cases of this sort.

Erb presents the matter more fairly than either of these writers. Accidents which occur in railway collisions, as other accidents may lead to a long train of nervous symptoms, and

when death has resulted, a *post mortem* examination may show little apparent cause for the fatal result. In the greater number of these cases the pathology is a riddle, which, for its satisfactory solution will need a great deal of experiment and careful and extensive *post mortem* investigation. The great trouble in coming to an opinion as to the nature and cause of a train of nervous symptoms following a railway injury is not whether we have to do with an actual or feigned train of symptoms. Usually the patient's symptoms are of such a nature that the physician can come to a conclusion without much trouble, but where he has to do with an intelligent and unscrupulous man who expects a large sum from a railway company, the case is one of extreme difficulty. In many of these cases it is almost impossible to come to a certain diagnosis.

In the words of a recent writer, the "needed clinical work, it seems to us, in the case of railway 'spine' is the determination of clearly defined types of the disease and the investigations of the variations from this type, and the certain relation to objective symptoms of the disease." That serious and even fatal effects may arise from changes in the cord where it has not received any direct injury has been abundantly proved. In the current number of one of our periodicals there is a very interesting case reported by Dr. Edmunds, of a soldier who was struck in the back with a bullet. He fell immediately and had to be carried out of action. The bullet entered the back two or three inches from the spine, and the physician who first attended him considered that the spine was severely injured, because the patient had lost complete control over both lower extremities. Patient had paralysis of the bladder and rectum also. There was cystitis and a bed sore over the sacrum before death which occurred five months after the injury. At the autopsy there was no fracture or indication of fracture or dislocation of the vertebræ to be found. The cord was seen to be much atrophied and softened about the level of the wound. On hardening the cord in Muller's fluid, it was seen that there was universal myelitis and softening about two inches opposite the wound, this gradually passing below into sclerosis of the lateral and anterior pyramidal tracts, and above into sclerosis of the posterior column. There was no indication of hemorrhage, either external or into the substance of the cord. Its surface was uninjured. This was undoubtedly a case of pure "spinal concussion." The immediate parphlegia following the injury could not have been due to any other cause. The case is then one of very great importance, as it proves most conclusively that we can have from a severe shock sufficient changes brought about in the spinal cord to cause death,

and that these changes were in the first place nothing more nor less than "concussion of the spine."

Very recently the opinion seems to be gaining ground that we may have tabes dorsalis arise from peripheral causes. That, in fact, an ulcer in the foot may be the *fons et origo mali* of this formidable disease. The origin of the disease in such cases is explained by first a peripheral neuritis gradually extending along the course of the nerves until it reaches the posterior roots, and there a similar process gives rise to a subsequent sclerosis of the posterior columns.

## EXPERIMENTS IN THE USE OF PASTES IN THE TREATMENT OF SKIN DISEASES.

Unna, of Hamburg, an ingenious and practical worker in dermatology, has of late years brought forward a number of new methods of treatment, among which is the use of pastes instead of ointments. The employment of ointments, particularly in dispensary practice, and in cases where fatty matters disagree with the skin, being often inconvenient, Unna has conceived the idea of using pastes of gum, dextrine and rubber, which are much cheaper than ointments, and which, in his opinion, are calculated to be particularly useful in moist eczema.

The results of Unna's experiments, with his formulæ, have been so frequently translated and copied that I shall not repeat them, but shall only give the results of my own experiments.

The first paste of which I made use is the following:

*Kaolin Paste, No. 1.*—

R.	Pulv. Kaolin,			
	Glycerinæ,	aa	12 dr.	
	Pulv. zinci.oxid.,		1 oz.	
	Liq. plumbi subacetat.,		1 oz.	M.

This makes creamy-white fluid, which, applied with a large, soft brush, soon dries, leaving a coating on the skin, which can readily be washed off with water.

*Case 1.*—Mrs. J. G., 66 years of age, a large, heavy woman with some tendency to varicose veins, came to the Polyclinic on July 9th, 1884, with an extensive eczema rubrum involving both legs, from the feet to above the knees: the eruption was red dry, and slightly scaly, though it had been moist and weeping at one period. It was acute, being of three week's duration. The kaolin paste No. 1 was applied with a brush thickly, over both limbs, and a bandage was applied from the toe to mid-thigh. The next day the patient returned, already much improved. At



this time another paste (kaolin and linseed oil No. 2) was applied to the right leg: but this did not seem to agree and was stopped. The patient was then once more placed upon the use of the first paste, under which she improved rapidly, but soon disappeared. She reported again, nine months later, with a limited chronic eczema rubrum of the leg, with some shallow ulcers, and she said at this time that she had gotten practically well under the employment of the kaolin paste.

*Case 2.*—Mary P., 42 years of age, well marked eczema rubrum of right ankle, back of foot and toes, severe and painful. Some weeping, six months' duration. July 11, 1884. Placed upon the application of kaolin paste, No. 1. Did well for a while, then hung fire. Paste changed to that of (kaolin and linseed oil, No. 2), under which a marked improvement took place, but the eruption went on very slowly toward recovery, until October 7, when ointments of various kinds were employed, and the disease disappeared about the end of January, 1885. Though a stubborn case, this was calculated to try the efficacy of the pastes, which cannot be said to have proved themselves unusually effective.

Another somewhat similar paste is that to which I have given the name of Kaolin Paste.

*No. 2.*—

R. Pulv. kaolin,	28 dr.	
Glycerinæ,	12 dr.	
Pulv. zinci oxidi,	1 oz.	
Liq. plumbi subacetat.,	1 oz.	M.

This forms an ointment-like mixture, which solidifies after a few weeks to a tough, putty-like consistency. By beating up with a spatula, however, the mixture returns to a workable consistency for a time. This was used in—

*Case 3.*—Mrs. B. B., 47 years of age, an enormously fat woman, presented herself on August 24, 1884, with a severe, wet eczema rubrum of the right leg, of two years' standing. Kaolin paste No. 2 was applied, but seemed to disagree, and its use was stopped. As the only difference between this paste and No. 1 is, that it contains a larger proportion of kaolin. I cannot imagine why this should disagree. Another paste (kaolin and linseed oil, No. 2) was substituted for it, under the use of which the leg slowly healed, in spite of the patient's unwieldly shape, and the probable great venous pressure on the lower limbs. On December 5th the paste was stopped, and a solution of tannic acid in collodion was substituted, for the purpose of hardening the recently formed skin, and in a week more the patient was discharged cured.

The following paste contains linseed oil, and is designated in my notes Kaolin-linseed Oil Paste, No. 1:—

R. Pulv. kaolin,	2½ oz.	
Ol. lini,	1½ oz.	
Lix. plumbi subacetat,	1 oz.	M.

This forms a convenient ointment-like mixture, having the consistence of very soft putty. It dries quickly, leaving a yellow crust.

*Case 4.*—Mrs. M., 60 years of age, eczema of the leg, mostly erythematous, but some exzema rubrum; considerable swelling of limb. After getting nearly well under other treatment returned June 20, 1884, as bad as ever. She was then directed to use kaolin-linseed oil paste, No. 1, applying daily and bandaging. Within a week a marked improvement was manifest, and within six weeks the patient was getting well.

*Case 5.*—James K., 65, marked case of eczema rubrum, involving the left leg and foot, of three months' standing. Several methods of treatment were employed, without a very satisfactory result, for about a month. On May 10th the leg was dressed with kaolin-linseed oil paste, No. 1, under which it improved steadily to August 29th, when the skin was reported brown and well at all points. A little thickening over the instep remained, for which a dilute tar ointment was employed.

*Case 6.*—John K., four years of age. Large patches of postular eczema, with considerable discharge and crusting, about six weeks' duration, following an attack of measles. Ordered well washed, and kaolin-linseed oil paste, No. 1, applied. Syrup of the iodide of iron internally. In two weeks well.

Kaolin-linseed oil paste, No. 2, is composed as follows:

R. Pulv. kaolin,	1½ oz.	
Ol. lini,	1½ oz.	
Pulv. zinci oxidi,	1 oz.	
Liq. plumbi subacetat.,	1 oz.	M.

This paste, as will be seen, differs from the previous one in the substitution of powdered oxide of zinc for a portion of the kaolin. It is a soft, putty-like ointment, resembling a rather tenacious, diachylon ointment. It is smooth and spreads easily.

*Case 7.*—Nicholas G., nine years of age. Patches of eczema squamosum and dry eczema rubrum on the front of the leg, below the knee, and elsewhere, of three months' duration. On July 15th, 1884, he was ordered to have kaolin-linseed oil paste, No. 2, applied. He was brought back three weeks later, very much improved. Later in the autumn a relapse occurred, for which other means of treatment were employed.

*Case 8.*—Margaret M., 45 years of age. Eczema rubrum outside of right ankles, with a number of shallow, painful abrasions. Simple kaolin paste, No. 1, having been used for some time without effect, this kaolin-linseed oil paste, No. 2, was applied, but without relief. An ointment of opium and belladonna was then substituted, by the use of which the pain and inflammation were much allayed.

*Case 9.*—Minnie H., 16 years of age, applied July 26th, 1884, with postular eczema of the forehead. Kaolin-linseed oil paste, No. 2, was applied, with very good results. A relapse, in the form of squamous eczema, took place later, for which other treatment was employed.

Cases 1, 2 and 3, all improved under the use of this paste after the simpler kaolin pastes had failed.

A paste of somewhat different character is the following:

*Sulphur Paste, No. 1.*—

R. Sulphur precipitat.,	2½ oz.
Pulv. calcii carbonat.,	1 dr.
Pulv. zinci oxidi,	10 oz. 2 dr.
Pulv. amyli oryzæ,	5½ dr.
Glycerinæ,	1 oz. 2 dr.
Aquæ,	9 oz. 7 dr.

This is Unna's formula, but I found that it "set" almost at once to a tough mass, sometimes almost as hard as plaster of Paris, which made it perfectly useless. The addition of glycerine to the proportion of about 20 minims to the ounce, or more, makes a soft and useful paste.

This was employed in half a dozen cases of acne, and always with advantage. But this preparation possesses no superiority to the washes and ointments commonly employed in acne, though, if regularly applied as a mask at night and washed off in the morning, it exercises a happy effect in severe cases. Like the other pastes described, it merits further trial.

I think the facts above given point to the employment of Unna's pastes as of advantage in hospital practice. They are cheaper than ointments, but must be made extemporaneously, or nearly so. I found in practice at the Polyclinic, that the pastes were more troublesome to have made than ointments. So long as I applied them myself, the patients did well, but when placed in the patients' hands to apply at home, the result was highly unsatisfactory. I intend to make some future investigations of other pastes devised by Unna, with the view of ascertaining their practical value.—*Arthur Van Harlingen, M.D., in Polyclinic.*

## HÆMATURIA.

In an article published in the *Detroit Lancet*, Dr. L. E. Maire gives the following suggestions on treatment:

The treatment of hæmaturia will depend to a large extent upon the cause. If due to external injury, rest must be enjoined; indeed, this will be found necessary in all cases of hæmaturia. Opiates, if required, and relieving the bladder of accumulated urine, so as to prevent fermentation. In active hyperæmia of the kidneys local depletion by the use of wet or dry cups over the region of the kidneys will be found useful, together with active purgation. In the passive form of congestion, general stimulants and tonics will be found more useful, such as sulphuric acid, tincture ferri mur., and the careful use of turpentine.

In cases of cancerous or tuberculous degeneration not much can be done, our attention being directed to prevent hæmorrhage as much as possible. The agents we use to attain this are rest, cold applied to the region of the diseased part, either in the way of external application or injection into the bladder, and the use of astringents or hæmostatics, such as ergot, gallic acid, digitalis, plumbi acetat, tr. ferri mur., alumen in solution and injected into the bladder, and turpentine where the hæmorrhage is not of renal origin. In one case I have been treating recently there seems to be a weakened condition of the sphincter vesicæ attending the hæmaturia, which was due to varices of the vesical veins. I added to the above remedies strychnine and belladonna in appropriate doses with marked advantage.

In the treatment of hæmaturia due to entozoa, I have no experience. The treatment recommended by Dr. John Harley, who studied the disease among the inhabitants of the Cape of Good Hope, is the one used. He recommends a draught consisting of 15 minims each of oils of turpentine and male fern, with five minims of chloroform in two ounces of tragacanth mucilage, to be given every morning. Where these entozoa were located in the bladder, he injected a solution of twenty to thirty grains of iodide of potash to five ounces of tepid water, every second or third day.

In hæmorrhage of the urethra very little difficulty, as a rule, will be encountered. Astringent injections, the application of cold and compression by means of card-board held in place by a number of elastic bands, will be found all that is required as a rule.—*Am. Med. Digest.*

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ABSCESS OF THE LIVER.

In a paper read before the New York State Medical Association, and published in the *New York Medical Journal*, Dr.



Janeway says abscess of the liver is more common in this country than is generally supposed. The symptoms are generally misleading, and good clinical observers often fail to detect its presence. Within the past year seven cases have come under my notice. In summing up attention is drawn to the following points in reference to the subject:

1. Abscesses of the liver can practically be divided into those affecting the left lobe, or the lower part of the right lobe, so that the abscess, when formed, produces an elastic or fluctuating tumor below the free borders of the ribs, and of those situated in the upper or posterior portion of the right lobe. The reason for this division is that abscesses in the two former situations are easy of access, of diagnosis, and of operative interference. The abscess in the last mentioned situation is the one which more often rise to difficulty in diagnosis, or, if diasnosticated, to doubt as to the best and safest methods of interference.

2. There are several methods by which the existence or non-existence of adhesions between the liver and abdominal wall can be made out. The presence of hepatic friction, audible or tactile, shows the absence of adhesion, but the probability that they will soon be formed. If, on palpation, the edge of the liver remains fixed, and does not descend with respiration, adhesions have, in all probability, taken place. Again, a long needle—that of a hypodermic syringe or aspirator—introduced into the liver will, if the outer end is left projecting some distance, move upward as the liver descends, and downward as the liver ascends, if no adhesion exists. But if these have formed, then the needle does not move.

3. The difficulties which arise in the diagnosis of liver abscess may, in many cases, be surmounted by a careful survey of the history of the condition of the liver, and by exclusion of the existence of sufficient disease in other organs to account for the symptoms.

The mistakes which I have seen made have been: *a.* To consider a liver abscess some other disease, as malarial fever (remittent and intermittent), typhoid fever, or tuberculosis. *b.* To consider an abscess of the liver some other disease of the liver, as hydatids, cancer, congestion, fatty liver, hyperplasia. *c.* To consider the swollen liver an aneurism of the aorta, especially in case of abscess of the left lobe of the liver, where pulsation was communicated to it by the aorta. *d.* To consider an abscess of the gall-bladder as abscess of the liver, and *vice versa*. *e.* To consider a supra-hepatic abscess an abscess of the liver. *f.* To consider an abscess of the liver one of the abdominal wall, and *vice versa*.

Some years since the writer had supposed that a distinction could be made between liver abscess and cancer of the liver by careful attention to the patient's temperature; but subsequent investigation has shown that in cases of rapidly growing or disseminating cancers a hectic type of temperature may exist.

4. As regards the etiology of liver abscess, I believe that many of the apparently idiopathic are of traumatic origin. I have, in several instances, ascertained its occurrence in persons who were in the habit of lifting heavy weights, particularly those who did so in hot places, as firemen, those unloading vessels, etc., by placing the right elbow firmly against the side, and then having the weight raised in this way. By this statement I do not mean to deny the probable influence of bacteria in the origination of abscesses, but to attribute to traumatism the establishment of that favorable condition which will allow of abscess formation.

In concluding, I may add to this paper, which is intended to present the subject in a practical manner, and as it has occurred to the writer, a few remarks on treatment. I believe that all accessible abscesses associated with an adherent liver are best dealt with by free incision, washing out with an antiseptic fluid, the introduction of a drainage tube, and by antiseptic dressing.

The use of the abdominal bandage is sufficiently manifest as a means of preventing motion of the liver, and of holding it fixed, and needs no special comment. The medical treatment must be symptomatic. The writer believes that rest, a cool climate, and strength of the patient, are the main ends to be attained. The most important point is to secure an early and safe exit for the pus.—*Am. Med. Digest.*

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## RESULTS OF OPERATIVE TREATMENT FOR EPI- THELIOMA.

Dr. C. Patsch, in a recent work, gives the results of his experience with epitheliomata in his surgical clinic, especially with the view of showing what changes in results treatment has accomplished in the last few years, since antiseptics have been used in their removal. His tables so far give the results of cases of carcinoma of the lip and external genitals operated upon between 1875 and 1882.

This work represents but a small portion of what the author has in contemplation: that is, the analysis of 580 cases of cancer of all parts of the body, operated upon between 1875 and 1882, and the condition of these patients at the end of March, 1884.

Cancer of the lip was observed in 98 cases; 88 were men and 10 were women, more than the usual percentage of female cases. In only two cases did it occur in the upper lip.

The average age of these patients when they presented themselves at the clinic was 57.3 years, and most of them had suffered a year or longer: 22 patients had suffered but half a year. Half of the entire number had infected glands when they came under treatment.

The disease began in most case between the 50th and 51st year, more seldom between 60 and 80, and only twice between 25 and 30 years.

Seventy-three per cent. of the men were exposed by their occupation to "wind and weather." Thiersch has also observed the disease to arise frequently under such circumstances.

Tobacco-smoking had but little influence in its production. In 12.2 per cent. of the cases it certainly arose from an injury to the lip. Many times the cancer was preceded by a suppurating wound. One patient had his lips wounded in the extraction of a tooth; this was immediately followed by a cancerous tumor, which had to be removed eight weeks later, but in spite of the early operation he soon succumbed to a return of the disease.

In some cases operation was refused, as the base of the mouth and the root of the tongue had become involved.

Four died soon after the operation: 8.3 per cent. later, from intercurrent disease; and 32.2 per cent. from a return of the cancer. Metastasis into the internal organs was not observed. The first return generally occurred between one and two years. If this was removed it generally returned in a few months; a third operation was usually immediately followed by a reappearance of the cancer.

In March, 1884, four of these patients were living with a secondary cancer: death had occurred in 28 cases, in the average period of 17.1 months after the operation. Some of these patients had had a second operation performed, and they died 13.6 months, on the average, after the last operation. The average duration of life after the first appearance of the cancer was 3.72 years.

There were living without any return of the disease 35.4 per cent.: five were still sick, as the removal had been followed by an extensive plastic operation. Six patients have remained free from disease between five and six years, and eight patients were still without return, though from seven to nine years had elapsed since the operation. On the average, 28 per cent. of those operated upon had remained free from the disease more than three, and 10.4 per cent. between one and two years. We only speak of a cure when three years have passed since the operation. In four cases the glandular involvement began only between two and two and a half years.

The prognosis in extirpation of the lip for cancer is moderately favorable, except where there is infiltration of the jaws or of the glands, especially so when a secondary operation is the one consideration. From the study of the clinical history of these cases the author finds that the period of lymphatic involvement depends more upon the character of the original growth than upon its duration.

The history of four cases is worthy of mention. In two the disease invaded the lower jaw, filled the alveolar canal, and pressed upon the mental and alveolar nerves. The other two cases had remained free from disease for eight or ten years after operation before a new malignant growth appeared.

Cancer of the penis was observed in twenty-one cases, nearly always between 40 and 60 years, once only between 20 and 30 years. Twice there was a congenital phimosis, and three times the disease was of traumatic origin.

Most of the growths sprang from the sulcus coronarius glandis, a few from the præputium. One case of direct infection from the prepuce to the contiguous head of the penis by a sort of vaccination is noted. Most of the cases presenting themselves were of long standing, any many of them had glandular involvement.

In one case a great thickening of the dorsal lymphatics could readily be perceived.

In some cases where there was decided glandular involvement a simple amputation of the penis without extirpating the glands sufficed for a cure: the glands decreased in size and did not afterwards become carcinomatous.

Amputation was performed as soon as the head of the penis became involved; the compression of the vessels was intrusted during the operation to the fingers of an assistant: the hemorrhage from the corpora cavernosa was controlled by deep stitches after the mucous membrane of the urethra had been stitched to the skin.

Two patients died from the operation, one from blood-poisoning; 14.6 per cent. remained healed at the time of making the report. Some cases had a return of the disease after an immunity of two and a half to three years. The secondary operations were usually unsuccessful. Nine cases in which the disease returned died, on an average, in 13.2 months, from inanition, hemorrhage, etc.

Carcinoma of the vulva was observed in nine cases, the average being 47.1 years: one patient was only 27 years old. In three cases it had existed for one year; in one case a small nodule had been present for eight years. The disease appeared mostly on the inner side of the labia majora, and on the posterior commissure.



Two cases were past operative procedure: one patient operated upon is now free from disease for three years; two died from recurrence, and one from some intercurrent disease. The author warns against the use of iodoform in patients who use stimulants to excess.—*Phil. Med. Times.*

## DIARRHŒAS.

As the season is upon us in which diarrhœas are abundant, it has seemed to us that a few remarks concerning their treatment may not be amiss. Of course we do not intend to give our readers a lecture on so familiar a subject as this, but there are certain points which we think are not generally appreciated by the profession, although they are not novel. The first of these is the value of sulphuric acid in the treatment of diarrhœas of relaxation. Many years ago we learned from the late Prof. Francis Gurney Smith the value of this remedy, especially in combination with the extract of hæmatoxylon. The following prescription we have tested almost innumerable times. It makes a very agreeable and efficient mixture, and may be given if necessary every two hours. Of course it should be varied, especially in the opium it contains, to suit individual cases:

R.	Acid. sulphur. aromat,	3	dr.
	Extr hæmatoxyl.,	3	dr.
	Tr. cinnamon.		
	Tr. opti camp.,	aa	1½ oz.
	Syr. q. s.,	ad	6 oz.

Stg.—Tablespoonful, as required, in a little water.

A second remedy, still less frequently used than sulphuric acid, but of great service in non-inflammatory diarrhœas, is carbolic acid, or, perhaps preferably, creasote. This remedy is especially useful in cases of lientery, with which there is such excessive nervous irritability of the bowels that food when taken passes right through. But it is also often very serviceable in ordinary summer diarrhœas. A very valuable combination, useful especially in sudden violent attacks, is afforded by the following perscription. It may be administered every half-hour at first: of course care must be exercised not to give the maximum dose too frequently:

R.	Chloroform.,	½	oz.
	Ol. caryophylli.		
	Creasoti,	aa	1 dr.
	Tr. opii,		½ oz.

Stg.—Shake well. Dose, 20 to 30 drops.

M.

In some cases, especially of more chronic or persistent diarrhœas, of which we have been speaking, where there is excessive acidity of the intestines, a combination of creasote with chalk or bicarbonate of sodium is very useful. Not rarely the addition of the creasote to an ordinary astringent cough mixture affords excellent results.

In regard to dysenteries, there are only two remedies which have in our hands given satisfactory results. One of these is calomel and the other ipecacuanha. Of the two the vegetable drug is the more universal in its application, although in the sporadic dysenteries, as seen in this climate, calomel is usually efficient. The objection to the use of ipecacuanha is the distressing vomiting which it is so prone to produce. The amount of vomiting is, however, very greatly affected by the method of administration. Some practitioners are accustomed to begin the treatment of dysentery by a large dose of the ipecacuanha in powder and endeavor to obtain tolerance after repeated vomiting. We have found that in many cases vomiting can be altogether avoided and the desired results achieved by giving the ipecacuanha in doses of 5 grains every half-hour, in pill form in combination with opium, or, better, by preceding each pill fifteen minutes by a dose of opium. In very bad cases with pronounced so-called bilious symptoms,—*i. e.*, excessively-coated tongue, epigastric tenderness or sense of weight, sick stomach and vomiting,—it is probably preferable to begin the treatment by giving the 5-grain pills every fifteen minutes until free vomiting is set up.—*Therapeutic Gazette.*

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### MANGANESE IN AMENORRHEA.

My attention was arrested some two years ago by an article on the use of binocide of manganese in amenorrhœa due to hygienic imprudence at the menstrual nisis, disturbances, etc. A short time thereafter Miss N., aged 17, came under my care. She had taken a severe cold at a dancing party, from the effects of which her menses, which were then on her, became suddenly suppressed. She presented symptoms of decline, with hectic, nervous chills, dry cough, and general malaise. After having for a reasonable period tried the usual remedies without result, I concluded to test the virtue of manganese pills. I had an impression that the grave symptoms were due to the suppression of the menses, and that with these re-established, improvement would ensue. I ordered one pill to be taken at bedtime every night. After five pills had been thus taken the catamenia appeared and under the use of wine and iron the patient was soon restored to her original good health.

I have since had two similar cases, which I treated in a similar manner with similar results. In one of these the suppression had existed for several years, and had been treated by eminent physicians both of Michigan and of the West, whither she had been sent in the hope of benefit from the change of climate. In this latter case fifteen pills taken nightly in the course of two weeks, in combination with tonic diet and medicines, wrought such a change that the patient became a regular patron of the roller skating rink, where she would exercise for two hours at a time without fatigue. The remedy is certainly one of great power in amenorrhœa.—*Dr. A. R. Hicks, in Medical Age.*

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### TREATMENT OF ANGINA PECTORIS BY THE IODIDE OF SODIUM.

Angina pectoris since the days of Gintrac and Lancereaux has been considered as a cardiac neurosis. Although in many cases a diseased condition of the coronary arteries and the aorta has been found, still the symptoms have been ascribed to a nerve disturbance dependent more or less on the innervation of the heart muscle or upon some degenerate change of nerve fibres. M. Henry Muchard, from a study of twenty-five *post mortem* examinations made at Hospital Vichart, objects to this view and ascribes the symptoms directly to degenerative changes with obstruction of the coronary arteries. He claims that true angina pectoris is the result of a disease of the arteries and not of the nervous system.

In accordance with this theory he advises remedies which have an effect on the arterial system. The iodide of sodium is especially recommended, given in doses of sixteen to thirty grains daily. He continues this medication during months and even years, and claims to have given complete relief and to have produced a cure of this dreaded disease in many cases. He thinks that the iodide of sodium probably acts by lowering the blood tension, relieving the walls of the artery and favoring the disappearance of the pathologic exudation. For the relief of the paroxysm he recommends the inhalation of the nitrite of amyl in four to six drop doses.

Although true angina pectoris has been assumed to be a neurosis, the remedies which have been mostly successfully employed have been those acting upon the arterial system. Occurring as it does at the ages when degenerative changes in the arteries are found and in subjects of such degeneration, it would seem that the theory advanced by Muchard should be carefully considered. That it is generally accompanied by high arterial

tension has been already recognized, and the drugs have been most successfully used which reduced this tension. Dr. Lauder Brunton has long since recommended the nitrite of amyl in reducing blood pressure, and we are indebted to Dr. Murrell for our knowledge of the value of nitro-glycerine as a remedy producing the same result. Both remedies have been successfully employed in relieving attacks of angina pectoris, but neither have been able to effect a permanent cure.

That the iodides from their well-known action of lowering the blood pressure and at the same time favoring the disappearance of pathological exudations may exert a healthy action in the earlier stages cannot be denied, but in cases connected with well developed atheroma more evidence is needed before it can be positively accepted.—*Courier of Med.*

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### SHORTENING OF THE ROUND LIGAMENTS.

At a meeting of the British Gynæcological Society, held June 10, 1885, Dr. Alexander (*British Medical Journal*, July 4, 1885) read a paper on the operation of correcting some uterine displacements by shortening the round ligaments. He said the operation had now been performed in nearly all the prominent cities in the world, and by most operators with more uniform success than generally befell any new operation. He never found any difficulty in finding and drawing out the ligaments. An incision was to be made upwards and outwards from the pubic spine, in the direction of the inguinal canal, for one and a half to two or three inches, according to the fatness of the subject. A considerable thickness of subcutaneous fat was then met with, which must be cut through by subsequent incisions, until the pearly glistening tendon of the external oblique muscle was reached. Midway through the fatty tissue an aponeurosis sometimes appeared, so firm and smooth that it might cause the operator to think he was deep enough, but he would find no ligaments at this spot. The first stage of the operation consisted simply in cutting down upon the tendon of the external oblique muscle until it appeared clean and shining at the bottom of the wound. The external ring was then found. The finger passed to the bottom of the wound detected the spine and the ring outside. Having isolated the external wound and tied any little vessels, the next step was to find the end of the ligament. By everting all the structures upwards the round ligament could be seen, generally at the lowest part, and with the white, easily distinguished genital branch of the genito-crural nerve along its anterior surface and close to it. The ligament at this stage was



more or less rounded in shape. It was an easily recognized flesh-colored structure. When the ligament was identified the small nerve on its surface was to be cut through without dividing any of the ligament. Then gentle traction was to be made, either by the fingers or by broad blunt-pointed forceps. Bands holding it to neighboring structures were cut through with scissors. As soon as it began to peel out, it was left and the opposite side begun. The final stage of the operation consisted in placing the uterus in position by the sound and pulling out the ligaments until they were felt to control that position. A curved threaded needle, with fine catgut, was used to stitch each ligament to both pillars of the ring, and the external abdominal ring was closed without strangulating the ligament as it lay between it. The ends of the ligaments were now cut off, and the remainder stitched into the wound by means of the sutures that close the incision. A fine drainage-tube was inserted, and the wound washed out with carbolic or other lotion before these sutures were tied. The after treatment consisted in rest. The tubes were removed on the second day, when the wound was dressed. The mortality of the operation might be set down as none. Three deaths had occurred but they were due to preventable causes. As mortality did not seriously enter into any consideration of the results of this operation, the real question at issue was whether it fulfilled the intentions of the operator and satisfied the expectation of the patient. The operation was designed to correct certain uterine displacements, and these alone. Whether the discomfort of the patient would be thereby relieved entirely depended on whether or not the symptoms were due to the displacement. To secure success the operation must be properly performed, and the after-treatment must be rational, so that no strain might be placed on the ligaments until sound union had taken place.—*Therapeutic Gazette*.

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## GASTRIC AFFECTIONS WITH A MALARIAL BASIS.

Rosenthal, of Vienna, observed seven cases of stomachic affections clearly traceable to a malarial element (*Deutsche Medizinische Zeitung*, May 21, 1885).

Several months usually pass before the latest malarial virus manifests itself in gastric difficulties. The absence of heightened temperature, febrile paroxysms, and splenic engorgement often leads to diagnostic and therapeutic errors. The marked intermittent fever which is often associated with neuralgia may also produce pains in the epigastric region: in other cases malaria assumes the mask of dyspepsia, intermitting vomiting, typical gas-

tric and intestinal pneumatosis, and of intermittent colic. This dyspepsia is usually mistaken for intestinal catarrh or enlargement, or if associated with emaciation and cachexia, for gastric ulcer or carcinoma. The more frequent occurrence of this form of dyspepsia in nervous persons, and the long-remaining nervous symptoms and psychic depression after the reappearance of the more urgent symptoms, point to the nervous element as an important etiological factor of the affection. Such at least is Leube's view, while others believe in local alterations, such as an œdematous infiltration of the gastric mucous membrane. Rosenthal gives some further diagnostic suggestions: cachectic, sallow appearance, and a rapid emaciation in young individuals with cardialgic and dyspeptic troubles, point more to malaria than to carcinoma, but may also indicate nervous dyspepsia. Intercurrent neuralgia (chiefly intercostal) corroborates the diagnosis of malaria.

The question of the origin of this malarial cardialgia is not yet definitely settled. Rosenbach regards the affection as an irritation phenomenon emanating from the engorged splenic capsule, while Rosenthal leans toward the assumption of an irritation of the bulbous vagus-centres, as also known to exist in the cardialgia of tabes and vomiting, in hysteria and neurasthenia.

As to the therapeutics of the affections, Rosenthal holds that quinine is not contra-indicated, but, on the contrary, acts well, provided large doses are given, and it is given, if necessary, as enema, suppositorium, or hypodermically. Besides quinine, Fowler's solution (5 to 8 drops three times daily), and tincture of eucalyptus globulus (1 dr. t. d.) are recommendable. Quinin. bor., internally (7 to 15 grains t. d.), or subcutaneously with glycerin and water, are also well borne, while quinin. salicyl. is worth trying. In chronic cases faradization of the spleen and the springs of Karlsbad, Kissingen, and Ems suggest themselves.

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### COLLES' FRACTURE.

John B. Roberts, M. D., Professor of Anatomy and Surgery in the Philadelphia Polyclinic, writes on the practical treatment of fractures of the lower end of the radius in the *Polyclinic*:

The essential point in the treatment of this fracture is early and complete replacement of the lower fragment. The protracted convalescence and frequent stiffness of the wrist and fingers, seen often in this injury, are, I am convinced, due to imperfect reduction of the fracture and to the confinement of the fingers during the use of the fracture dressing. When there is neither comminution nor loss of tissue by crushing, the fracture

can usually be cured in four or five weeks, with little or no difficulty, and without stiffness of the fingers. When comminution and crushing exist, cure without impairment of motion, though probably with more or less persistent deformity, is nearly always possible, and in the same time. When I say "cured," I do not mean that every vestige of swelling and of osseous thickening disappears so soon, but that the limb is capable of performing its ordinary functions. Old and rheumatic patients may perhaps exhibit a greater tendency than others to rigidity of the joints; but I cannot insist too strongly on my belief that stiff fingers are usually an indication of imperfect reduction of the fragments, which, by their projection, interfere with the extensor and flexor tendons, and cause adhesive inflammation.

No apparatus should be applied that restricts, at any period of the treatment, full and free motion of the fingers. In uncomplicated cases the splint need not be worn more than about ten days, provided that the patient is sufficiently intelligent to avoid submitting the arm to unexpected strains and blows. This is because of the slight tendency to reproduction of deformity in the properly reduced uncomplicated fracture. In careless patients, and in comminuted or otherwise complicated fractures, support by the splint should be continued for three weeks. I should be willing to treat many uncomplicated patients in intelligent persons without any splints, merely substituting a band of adhesive plaster firmly placed around the seat of injury. Passive motion is probably never necessary if the fracture is properly reduced, and the play of the fingers not restricted during the use of the splint.

Reduction is always painful, but is usually so quickly accomplished that I seldom use an anesthetic. Ether or nitrous oxide should be employed, however, if there is likelihood of the pain preventing perfect coaptation of parts. The surgeon must employ force directly to the fragments. Let him put the patient's hand in the prone position, grasp the middle of the forearm with one hand, and take hold of the patient's palm with the other hand in such manner that his thumb can make strong pressure upon the apex of the dorsal prominence. By making traction on the hand of the patient, and then suddenly flexing the patient's wrist, while at the same time he presses with his thumb strongly upon the projection at the back of the wrist, he can nearly always force the lower fragment into its proper position without difficulty. A repetition of this maneuver is sometimes requisite before accurate replacement is obtained. The grating produced as the fragment, which may have been impacted, is driven into its normal position can at times be distinctly heard by bystanders. The limb at once assumes its normal contour. The



disappearance of the bony edge, or shoulder, previously perceptible to the touch, where the upper margin of the lower fragment was elevated above the level of the shaft of the radius, is an indication that reduction of the backward displacement has been accomplished. Still further manipulation may occasionally be necessary to reconstruct the normal outline of the radius, which has at the wrist, it will be remembered, a concave palmar surface.

If great comminution or crushing has been incidental to the fracture, perfect restoration of shape may be impossible, although the deformity can be greatly diminished. In such cases also, retention of the fragments in good position may be difficult. Firm impaction, or entanglement of the fragments in the tendons or in dorsal periosteal bands, may require that the hand and attached lower fragment be first bent strongly backward, in order to relieve the interlocking before making traction, flexion and pressure. This preliminary measure is very seldom necessary. After reduction has been accomplished, any form of dressing is allowable, provided it immobilizes the limb, does not tend to obliterate the normal curve of the palmar surface of the radius, and permits the patient to move his fingers. It was formerly thought that splints deflecting the hand to the ulnar side exerted traction on the radial side of the wrist, and were therefore indicated. This is incorrect teaching. Such splints are unnecessary, as the deflection only causes the carpus to roll in the articular surface of the radius.

The hand should be placed in the prone or semiprone position, and a single splint extending from the elbow joint to the middle of the metacarpus, applied either to the dorsal or palmar aspect of the forearm. It is essential that the palmar splint, if it be chosen, should be convex on its upper surface at its carpal extremity, so as to preserve the integrity of the radial concavity, and not to make the palmar surface of the radius flat by forcing upward the lower fragment, which has just been pushed down into proper position by the surgeon's manipulations. This convexity of the splint may be obtained by using the moulded splint of Levis, which I employ, or a splint with a hard convex pad, such as that of Carr. It should be seen that the pad properly fits. The surgeon can readily make a pad out of soft wood and fasten it with screws to a straight splint. No dorsal splint is needed with either the Levis or Carr palmar splint. If it is inconvenient to obtain a proper form of curved palmar splint, a flat splint may be applied to the dorsal surface of the radius, for it presents no curve, but is straight. Bond's splint, so frequently employed in Philadelphia, is dangerous to the future contour and utility of the limb, and should never be used.



After the splint has been employed for from ten to twenty days, varying, as above stated, with the kind of fracture and disposition of the patient, it is well to substitute it by a strip of adhesive plaster two inches wide, applied circularly around the wrist, so as to give moderate support to the partially consolidated fracture.

If union has already occurred in a fracture treated without proper reduction, I should be inclined to attempt refracture and adjustment, even after the lapse of several months; provided that the fingers were very rigid or the deformity very great. It is not likely that as much can be accomplished in such cases as was possible immediately after the receipt of injury; nor should it be forgotten that very good, if not perfect use of the hand finally is compatible with a considerable degree of deformity. Rigidity of the fingers, if permitted to occur, remains, however, for many months.

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#### A VALUABLE REMEDY FOR HEADACHE.

The *Physician's and Surgeon's Investigator* desires to call the attention to a simple, and at the same time wonderfully efficient, treatment for many kinds of headache:

We lay no claims to originality, nor do we know who the originator was, but having used it for a year or more, and in many cases with remarkable results, we feel disposed to give it our indorsement, and desire to make it more generally known. The remedy is nothing more nor less than a solution of the bisulphide of carbon. A wide-mouth glass-stoppered bottle is half filled with cotton or fine sponge and upon this two or three drachms of the solution are poured. When occasion for its use occurs the mouth of the bottle is to be applied to the temple or as near as possible to the seat of pain, so closely that none of the volatile vapor may escape, and retained there four or five minutes or longer. For a minute or so nothing is felt, then comes a sense of tingling, which in a few minutes—three or four usually—becomes rather severe, but which subsides almost immediately if the bottle be removed, and any redness of the skin that may occur will also quickly subside. It may be re-applied, if necessary, several times in the day, and it generally acts like magic, giving immediate relief.

We believe this was the basis of a once popular nostrum. The class of headache to which it seems especially adapted is that which may be grouped under the broad term of "nervous." Thus neuralgic, periodic and hysterical headaches are almost invariably relieved by it. True, the relief of a mere symptom is quite another thing from the removal of a cause, yet no one who

has seen the distress and even agony caused by severe and frequently recurring headaches (and who has not?) but will rejoice to be able to afford relief in so prompt and simple a manner; besides it is sure to secure the hearty gratitude of the patient if he has suffered long. As to the *modus operandi* we have nothing more definite than a theory to offer, and that is that the vapor being absorbed through the skin produces a sedative effect upon the superficial nerves of the part to which it is applied. We know by experiment that its influence is not due to its power as a counter irritant. We however know that it does act, and if we do not clearly see in what way it acts, that is no more than can be said of several other remedies which are firmly established in professional favor and confidence.—*Weekly Medical Review*

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### PERFORATING ULCER OF THE BLADDER.

Dr. James Oliver thus writes in the *London Medical Times*:

The type of ulcer I am about to describe as affecting the bladder, has hitherto been looked upon as more or less peculiar to the stomach and duodenum. When, however, we consider the probable cause of its formation, it is not to be wondered at that other parts of the intestinal canal, and even the bladder itself, may become the seat of a similar necrotic change. In the *Lanect*, March 7th, of this year, I recorded a case in which the ascending colon had been thus perforated, and doubtless careful pathological observation will prove that such are not uncommon.

Perforating ulcer of the bladder is primarily always acute; if, however, there be extensive destruction of tissue, the functions of the organ are likely to be permanently disturbed, and the disease to become one truly chronic in character. This ulcer is especially apt to recur, a fact strongly in favor of a diathetic tendency or proneness to the affection. It usually develops without signs of inflammation or suppuration, and as in the stomach and other parts of the intestinal tract, apparently results from a plugging of the vessels which run in and nourish the coats of the viscus. If the blood supply to any tissue of the body be suddenly withdrawn—as happens when a vessel becomes occluded—and collateral circulation be not readily established, death of the part is inevitable. Embolism and thrombosis are the most frequent causes of softening in the brain and spinal cord, and it is more than likely that these play an important part in the production of perforating ulcer of the bladder. Round ulcers, similar to those we are now considering, have been produced in the stomachs of animals artificially by the introduction of emboli into the gastric vessels. This form of necrosis is truly analogous

with dry gangrene occasionally seen in the extremities of the aged, where the arteries, because of the degenerative changes in their coats, have become impervious. The embolic theory of chorea is still tenable, and all who see much of this disease remark its frequent association with rheumatism or a rheumatic predisposition. Judging from those cases of perforating ulcer of the bladder which have come under my notice, I am inclined to believe that the rheumatic diathesis augments the tendency to this affection, and favors embolism as a probable cause of its production. In one case the symptoms attributable to perforating ulcer developed during an attack of acute rheumatism, and as the patient died sometime after, opportunity was afforded for examining the bladder and verifying the diagnosis. The heart in this case showed no trace of valvular disease. Females, it would appear, are more prone to this affection than males, and especially about the period of puberty. No exciting cause can as yet be suggested.

One or more ulcers may develop, according to the number of vessels occluded: some days, however, must necessarily elapse before disintegration is completed. Whether the necrotic change shall invade the whole thickness of the bladder wall or not, depends on the seat of obstruction of the artery, the completeness or incompleteness of the plugging, and the period at which collateral circulation becomes established. Should, however, the destructive process attack all the coats of the bladder, and at a part covered by peritoneum, this coat tends to thicken and form adhesions with neighboring structures, it may be the small intestine or omentum, thereby preventing rupture of the organ, extravasation of its contents, and death by shock or peritonitis. If the bladder forms adhesions with any part of the intestinal canal the ulcerative process may extend and invade this organ too; vesico-intestinal fistula, though fortunately rare, may therefore depend upon simple perforation. In such cases even a careful inquiry into the clinical history may fail to reveal the probable starting point.

The symptoms and course of perforating ulcer of the bladder are usually very insidious, and fatal peritonitis may result from destruction of all the coats ere the grave condition has been recognized. Pain more or less constant and referred to the hypogastrium is a frequent symptom—it is aggravated by pressure and by any slight distension of the organ. There is frequency in micturition, and the pain, as a rule, becomes sharp and cutting in character towards the end of the act. The most distressing symptom of all is tenesmus, which results from spasm of the muscular coat, and may continue for some time after the organ has completely emptied itself. Blood usually appears in



the urine about the third or fourth day, is small in quantity, and is expelled with the last drops of urine. The treatment is rest and bland food: opiates must be given to relieve pain and the intense bearing down.—*Lancet and Clinic*.

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### THE TREATMENT OF DIPHTHERIA.

Dr. J. W. Alexander, of Newark, O., writes in favor of the constitutional treatment of diphtheria. He thinks that local applications of any sort are of doubtful utility, although, as palliative measures, antiseptic and disinfectant washes are not to be ignored. All caustics and irritants are injurious, he maintains, and should never be used. The following is the formula which he has used with success in many cases: R. Chlorate of potassium, 40 grains; simple syrup (slightly warmed), 2½ ounces; dissolve and add aromatic sulphuric acid and tincture of chloride of iron, of each one fluidrachm. The dose for adults is a teaspoonful every two to four hours, according to the urgency of the case. As soon as the symptoms begin to improve the dose should be decreased and the interval extended, but the remedy should not be discontinued until the throat is entirely free from the diphtheritic deposit. Dr. Alexander states that he has used this method of treatment constantly for several years, during which time he has lost but one case of diphtheria, and that one was not seen until the disease was too far advanced to be stayed by any remedy. He writes in conclusion: "It may seem that there is nothing remarkable in the above combination, as chlorate of potassa and tincture of iron are used by nearly everyone, but the union of the three articles combined in these proportions has produced very marked results. I will not attempt an explanation of the *modus operandi* of this medicine, but will leave it to those who are more competent; but if I can persuade any of my professional brethren to give this simple remedy a trial, I shall have accomplished my purpose."—*Medical Record*,

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### HOUSEMAID'S KNEE—RECOVERY WITHOUT REMOVAL OF THE SAC.

Dr. Charles H. Carter, of Chicago, Ill., relates the case of a plasterer, aged thirty-four, who had received a fall three weeks before coming under observation, striking his knee against the edge of a board. No pain was felt until about a week after the injury had been received, at which time also a swelling was noticed. This tumor increased in size until it covered the lower two-thirds of the anterior surface of the patella, and was found



to contain pus. There being no time for temporizing, Dr. Carter proceeded to operate as follows: "With a bistoury I made an incision from above downward on the external side of the swelling, carrying it, with the aid of a grooved director, to the extreme lower limit of the cyst, so as to avoid leaving a 'pocket,' and to facilitate complete evacuation. The incision was made on one side, and from above downward, rather than from side to side, to prevent any gaping of the wound when the knee was flexed.

"After thoroughly emptying the sac by gentle pressure and gravity, I washed out the cavity with a two per cent. solution of carbolic acid in hot water, continuing until the water returned perfectly clear and unstained by either blood or pus. The time consumed by this part of the operation was probably ten minutes. I used hot water because that was more certain to dislodge any portion of pus which might, by its greater consistence, be retained around the edges of the sac, where the walls are reflected on the surface of the patella.

"Gently pressing out the water, but not taking any pains to thoroughly empty the sac, I carefully brought together the edges of the wound and hermetically sealed it with strips of silk isinglass-plaster, moistened with a ten per cent. solution of carbolic acid. Then, with the leg extended, I applied strips of moleskin plaster to the whole knee-joint. I used strips about half an inch wide, and long enough to go about three-fourths around the joint, leaving the posterior surface uncovered.

"Commencing above the patella, I applied the first strip, drawing the ends strongly downward. The second slightly overlapped the first in front, but nearly covered the ends of it on the sides. The strapping was continued in this manner so that the strips firmly compressed every portion of the emptied sac, keeping the walls accurately in contact. The patient did not experience the least pain or discomfort in the part after the dressing was applied.

"Using no further means, except complete rest and low diet, I removed the dressing on May 5th, four and one-half days after the operation, and found the sac perfectly closed and not a drop of liquid to be found in it.

"After remaining in-doors two days longer, the man went to his work, and has had no sign, as yet (June 30th), of a return of his 'housemaid's knee.'—*Medical Record*.

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## THE EMERGENCIES OF SURGERY—INJURIES OF HEAD AND FACE.

The following is the first of a course of lectures delivered at the Meath Hospital and County Dublin Infirmary by Lambert Hepenstal Ormsby, M.D., F.R.C.S.:

Injuries of the head are at times followed by the most alarming symptoms, even when the appearance and size of the injury are of the most apparently trivial character. The patient after a fall or blow may seem to recover the shock, and to suffer no bad effects. However, in the course of a few hours the patient may become comatose. Mr. Guthrie mentions on this subject "Injuries of the head affecting the brain are difficult of diagnosis, doubtful in their character, treacherous in their course, and for the most part fatal in their results." It must, however, be borne in mind that the truth of this observation does not always follow, for in some exceptional cases, no matter how severe the injury may appear, the patient may recover without a bad symptom, and in the whole course of medical practice no case presents itself to the surgeon ready for any emergency so important as these forms of injury. No hasty diagnosis should be formed, no heroic line of treatment adopted more than an anxious careful attention to each symptom as it arises. Mr. Liston has also stated with reference to this subject "that wounds of the head of the most trivial character are not to be despised, or of the most severe not to be despaired of."

Contusion of the scalp may result from falls or blows from blunt instruments, the immediate effect of such an injury is great swelling, tension and pain; the integument over the spot becomes glazed and tender, in a few hours it may become discolored by extravasation of blood into the subcutaneous tissue. Children are very liable to such injuries by falling off chairs or tripping when at play and their head coming in contact with some hard substance. Anxious mothers and nurses are in the habit of applying a variety of nursery remedies for such to keep down the swelling and prevent the skin turning black.

*Treatment.*—Immediately after the injury the local application of a small piece of ice, or the application of a flat piece of steel or iron, or a flat stone. Almond oil or camphorated oil is also a favorite remedy to apply to the part at once. The application of vinegar and water or a spirit lotion on lint is also most useful. Where the skin is not broken, cleaning out the bowels with a mild saline purge, a non-stimulating diet and perfect quietness would be about all that need be done in slight cases. In severe contusions, where a large blood tumor immediately forms, the diagnosis and treatment may be more perplexing, for it must be remembered that this has frequently been mistaken.

for a depressed fracture of the skull, and *vice versa*. In general terms the diagnosis can be made out pretty well by the history of the case. In a bloody tumor of the scalp if it is carefully examined with the finger, it is found that there is a circumscribed tumor present with a well-defined firm margin, and in the center of which the finger, as it were, sinks into a soft, depressed center. In a fracture with depression the circular margin is not at all so apparent, and the depression is hard instead of soft to the touch, and if the depression has existed for any time it is most probable symptoms of compression will be present.

Treatment for severe contusions consists in the application of cold evaporating lotions to cause the extravasated blood to be absorbed. In other cases suppuration may take place in the tumor, and when this is evident an incision must be made, and a free exit given to the matter. Erysipelas and diffuse abscess of the scalp may occasionally follow such injuries, whether trivial or severe, together with inflammation of the brain and its membranes.

Pott's puffy tumor indicates the presence of a collection of pus situated between the dura mater and the cranium, with a puffy and swollen condition of the epicranial aponeurosis following a severe blow or contusion. When this condition is present probably slight symptoms of compression will begin to make their appearance.

*Treatment.*—Keep the patient in bed in a dark room on light and non-stimulating diet. When evidence of compression appears the operation of trephining over the seat of the injury to give exit to the matter should be performed without delay.

Wounds of the scalp are of common occurrence, whether the result of falls or blows with blunt or sharp-cutting weapons. As a rule these wounds bleed very profusely, in some instances the smaller branches of the temporal and occipital arteries are severed and require to be commanded either by pressure, ligature, torsion, or acupuncture needle. A portion of the scalp may be considerably torn and partially detached, as after mill accidents or railway smashes.

*Treatment.*—In a clean-cut incised wound remove all dirt or foreign matter that may have found its way into the wound. Cut the hair very close about the edge of the wound, and evenly approximate its edges with good adhesive plaster. Do not apply sutures is an old maxim you are expected to follow. Some part of the scalp may slough, however. This will be repaired by healthy granulating tissue. Abscesses may form, which must be evacuated as soon as recognized. All hemorrhage stopped by pressure or other means; edges of wound brought evenly together; the patient kept quiet; the bowels kept moderately open



by saline purges, and light, non-stimulating diet ordered for the first few days—comprises nearly all that need be done in a case of the kind.

*Erysipelas of the Scalp.*—A complication that occasionally arises after a contusion, a punctured or incised scalp. Much depends on the state and constitution of the patient at the time of the accident, as well as the sanitary and hygienic conditions, which may be at fault. The premonitory symptoms of erysipelas coming on are as follows: Locally, wound becomes glazed and dry, no pus appears on edges; a deep red blush over the part is very apparent; also tingling, heat, and swelling, giving rise to much pain. Constitutionally, we have a high temperature, a dry, furred tongue, a quick pulse, loss of appetite, high-colored and scanty urine, headache.

*Treatment.*—A linseed poultice should be applied if the swelling is very great with a swollen and puffy condition of the epicranial aponeurosis. Incisions should be made with caution, to relieve tension, and warm fomentations. The bowels should be kept clear, and iron, quinine, opium, and strong beef tea administered internally.

*Fractures of the Skull.*—Of this we have many varieties. Generally, however, it is divided into fracture of the vertex and fracture of the base. Of the vault, or vertex, we have *depressed*, a small portion of bone is driven inward, and *non-depressed*, where there is no separation or depression, but just simple linear fissure of the cranial bones in one or more directions. The outer table may be furrowed or grazed by the passage of a ball across the skull. Much of the scalp must necessarily be torn and separated from the bone, which will in all probability produce necrosis, sloughing, abscess, ulceration, and sympathetic inflammation of brain and membranes.

*Treatment.*—The same as adopted in other head injuries. Wound treated on general principles. Contusion of the scalp with depressed fracture without a wound. This kind of an injury may puzzle one what to do. But the general rule in surgery is to adopt the following course: Where you have no wound, no symptom of compression, but with depression, wait for symptoms to arise before attempting to trephine or elevate, as before doing anything you must necessarily convert a simple fracture into a compound. 2. Where you have a wound in the scalp communicating with the seat of depressed fracture elevate or trephine, whether you have symptoms of compression or not. Sir William McCormac mentions on this subject what I may be allowed to quote with advantage: “One point regarding which opinions vary somewhat is respecting the treatment of depressed fracture unaccompanied by symptoms and with an ex-



ternal wound. Where there is no wound he would be a hardy operator who should cut down upon a depression in the skull in the absence of any symptom of compression. When there is a wound, however, the case is different; but even here I question much if the surgeon ought to do more than simply remove such loose fragments as can readily be got at."

Fracture of one table singly without the other is sometimes spoken of as regards the inner table, but its frequency is a matter of considerable doubt, and Guthrie mentions he has never seen it occur without positive marks of injury on the bone of pericranium.

*Treatment* for fractures of all parts of the vortex, it must be remembered, that as regards the result, recovery is far more likely to occur than those of the base. If it is merely a linear fracture the patient should be kept quiet, cold water dressing applied. Sometime profuse suppuration follows, when it is advisable to apply a light linseed-meal poultice. If a portion of bone has been driven in on the brain, together with the missile or bullet that produced the fracture, an attempt should be made to remove it. The fragments sometimes get displaced for some little distance under the cranium, away from the opening, in which case the removal is difficult, and any undue manipulation or exploring may drive the foreign body farther in on the brain, to be followed by greater injury and fatal cerebral mischief. By gentle manipulation with a probe, elevator, and forceps it is sometimes easy to remove the fragments. And in all cases elevation should be adopted and practiced in preference to trephining where feasible, as the operation is much more simple and much less dangerous to the patient. The operation of elevation is thus performed: If the wound is not large enough it may be increased by incision with a scalpel. The epicranial aponeurosis should be gently raised with a forceps, so as to see clearly the amount of depression and the line of fracture. A probe may then be passed between the fissure so as to ascertain whether the depressed portion is movable or not. If it is, the elevator is then gently insinuated in the fissure and the finger placed flat at edge of wound acts as a fulcrum for the elevator or lever to work on. If a sharp point of a spicula prevents the elevator being used, this portion may be sawn through with a Hey's saw. After removal all hemorrhage must be arrested, which generally wells up out of the wound, cold water dressing applied, and the patient carefully watched. Suppose this operation of elevation can not be adopted, he must then have recourse to the more severe form of procedure, viz: the operation of trephining.

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PERSONAL OBSERVATIONS OF THE WORK OF  
LAWSON TAIT.

In no way can a clearer insight be gained into the methods and work of the surgeon than by a personal observation of his clinical material. During the past few years Mr. Lawson Tait, of Birmingham, England, has given ample proof by his writings and statistics that his work in abdominal surgery was not only bold and original, but eminently successful. Mr. Tait works in his own private hospital, and his methods have not been so open to public inspection as those of surgeons who operate in large public institutions. Since Mr. Tait began to develop as the leading abdominal surgeon in England, many statements have been made which were intended to cast discredit upon the operator's truthfulness, and upon the correctness of his statistics and methods. It is but just to Mr. Tait to say that he has lived down the injustice of these insinuations against his work, and to-day stands at the head of his profession as a careful, painstaking and skillful surgeon.

Opportunities for the study of Mr. Tait's clinical material are quite limited, but now and then this privilege is accorded to an American surgeon. Recently Dr. A. Vander Veer, of Albany, New York, has enjoyed this privilege. Dr. Vander Veer now gives the profession the results of his personal observations on the work of Mr. Tait, in the *American Journal of Obstetrics*, etc., for July, 1885. We are informed that Mr. Tait is not only an original thinker, but a careful, cautious and great surgeon. "His hospital is a model of all that we could wish regarding quietness, cleanliness and perfect system, not only in nursing, but in everything. The discipline is the outgrowth of years of hard work and close application, and yet Mr. Tait is scarcely forty years of age. He has described quite fully in his book the necessary preparations incident to an operation, and yet to witness all is a study. Everything is arranged by the nurses after being told of the nature of the operation and the hour of operating. He selects young, intelligent and prepossessing women, whom he trains for the work he so much enjoys, and they in their desire to learn and please become true enthusiasts in the struggle to save life. He will not have morose, untidy, or homely women as nurses. Mr. Tait enters the room, and almost at a glance tells whether all required instruments are selected. He brings his bag of carefully prepared sponges, and counting them again, tells the assistant nurse their number, and she is held responsible for them. So also in regard to the number of forceps and other instruments." Dr. Vander Veer next relates Mr. Tait's method of preparing the sponges, "New

sponges are first put into a large quantity of water with sufficient muriatic acid to make the water taste disagreeably acid. They remain in this mixture until all effervescence has ceased and all the chalk is removed. For this purpose it may be necessary to renew the acid several times. The sponges are afterward carefully and thoroughly washed to make them as clean as possible and free from every rough particle. After being used at an operation, they are first washed free from blood, and then put in a deep jar and covered with soda and water (one pound of soda to twelve sponges). They are left in this about twenty-four hours (or longer if the sponges are very dirty), and then they are washed perfectly free from every trace of soda. This takes several hours' hard work, using hot water, squeezing the sponges in and out of the water and changing the water constantly. Leaving them to soak for a few hours in very hot water greatly assists in the cleansing. When quite clean they are put in a jar of fresh water containing about one per cent. of carbolic acid, and after being in this for twenty-four hours they are squeezed dry and tied up in a white cotton bag, in which they are left hanging from the kitchen ceiling (being the driest place in the house) till they are wanted."

The true secret of Mr. Tait's success is found in the very close attention given to minute details. Neatness, system and order prevail throughout his hospital, which, from the description given by Dr. Vander Veer, is a model of comfort and cleanliness. Mr. Tait looks after everything himself, and is so surrounded with trained and disciplined assistants that his work is executed in the most perfect manner. His sole aim has been to secure results, and to reach this end he brings to bear upon his work every prerequisite. The genius of the man flashes out, not only in his remarkable dexterity and skill with the knife, but in the infinite pains and alert watchfulness given to every case. Mr. Tait's success in abdominal surgery is an illustration of what can be achieved by any surgeon who is able to control the surroundings of his patients, and thus raise the practice of the science to the highest plane of art.—*Maryland Med. Journal*.

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### THE CHLOROFORM TREATMENT FOR TAPE-WORM.

Dr. Alfred W. Perry, of San Francisco, reports in the *Medical Record* an obstinate case of tænia lata, successfully treated by the exhibition of chloroform. The patient, a stout man, aged forty, had had tape-worm for eight years, on which he had tried all the hitherto known remedies. He always vomited the rem-



edy used within half an hour, retaining longest the French capsules of male fern extract. Dr. Perry had made two attempts to dislodge the worm, without success, when he saw the chloroform treatment noticed in the *Medical Record*. He used in the following manner, with entire success: The patient was made to fast from 12 M. of the previous day, and only allowed to drink lemonade. At 7 A.M. he took one drachm chloroform in one ounce of mucilage; at 8 A.M. one ounce of ol. ricini. The entire worm passed about 10:30 A.M. The patient was in considerable stupor shortly after taking the chloroform, which stupor lasted three or four hours. He was a large man, weighing 180 pounds. Dr. Perry thinks that one drachm of chloroform should not be exceeded as a dose.

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### GUNSHOT WOUND OF THE BRAIN—RECOVERY.

Dr. Willis Butterfield, of Belvidere, Ill., reports to the *Medical Record* an interesting case of a little girl, Gertie M——, ten years of age, who was standing talking to a companion, and suddenly sank down to the ground apparently lifeless. Her playmate heard a queer noise, which was the “spud” of the bullet, which struck the girl’s head an inch above and behind the right ear. When Dr. Butterfield saw her, a few minutes later, she was wholly unconscious, and on the walk where she fell was a pool of blood containing about a teaspoonful of brain substance. Within half an hour an ecchymotic swelling appeared above the eyeball in the outer part of the right orbit. Blood had flowed from the nose immediately after the injury was received. Dr. John Best, of Arlington Heights, was called in consultation. The opening in the skull was round and clean cut on the outside, but splinters of bone could be felt projecting from the inner table. An elastic catheter about the size of the external wound was used for purposes of exploration, as being less likely to injure the sound tissue. This passed about two and a half inches into the brain and pointed in the direction of the right orbit, but the ball could not be detected. On account of the swelling and discoloration about the eye it was thought that the ball had fractured the orbital plate, though no foreign body could be felt in the orbit. The wound was carefully dressed antiseptically, all spiculæ of bone projecting from the inner edge of the cranial wound being removed. The probing and removal of bone fragments caused no pain, but the patient moaned whenever the scalp wound was touched. Two or three hours later the child spoke a few rational words, and the mental faculties were gradually restored during the next few days. The tem-



perature did not at any time rise above 101 F. There was no paralysis, and slight headache was complained of during the first few days only. In three weeks the child was out-doors at play. The right eye remained more prominent than the other, and at times there was double vision. After having made a number of examinations without result, Dr. Butterfield at length discovered the ball in the right orbit, between the inner wall and the globe of the eye. The patient being anæsthetized, an incision was made in the conjunctiva, and a 32-calibre ball extracted. The eyesight soon became normal, and the little girl attended school the following autumn with all her mental faculties unimpaired.

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### SCUTELLARIA LATERIFLORA IN THE TREATMENT OF ENURESIS.

Dr. A. H. Winermark, of Cambridge, Ill., writes to the *Medical Record*: "Having read the excellent article on enuresis, by Dr. Stein, and the remarks of Dr. Willeford upon its treatment by *rhus aromatica*, I wish to contribute from my store of experience in the treatment of the same difficulty. Some two years ago I was advised by an old practitioner to use fluid extract of skullcap in a case in my own family, and the result was most gratifying. I have since employed it in several cases dependent upon nervous conditions only, and must say that results obtained have always been most satisfactory. A lad, twelve years of age, who would urinate from three to six times every night during his sleep, and had done so for several years, received one drachm t. i. d. for two weeks, and was speedily and permanently cured. All the cases occurred in children."

Dr. Winermark advises a trial, at least, of *scutellaria* when other remedies have failed. He disclaims any credit for originality in the use of the drug, as he says that it was recommended to him by another.

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### CLASS-ROOM NOTES.

To slight erosions on the nipples, Prof. Parvin applies tinct. benzoin.

Prof. Bartholow says that the most effective treatment of cholera is by chloral. The effectiveness of this remedy is increased by combination with morphine.

To wash out the vagina during pregnancy, Prof. Parvin recommends the use of a solution of borate of soda, 1 dr. to pint.

Prof. Da Costa placed a choreic boy, who was also decidedly lanæmic, upon:

R.	Tinct. ferri chlor.,	10 drops.	
	Arsenici chlor.,	1.40 gr.	
	Syrupi simplicis,		
	Aquæ,	aa	2 dr. M.

SIG.—Ter die. The arsenic to be increased.

To a *caput succedaneum*, Prof. Parvin advises the application of a solution of muriate of ammonium. Do not open it to let out the blood, but should pus form make a free incision.

In summer diarrhœa, the following has been found useful:

R.	Aquæ camphoræ,	3 oz.	
	Tinct. lavand. comp.,	1 oz.	
	Tinct. opii.,	1 to 2 dr.	M.

SIG.—Tablespoonful every hour or two.

When a child is very feeble, etc., at birth, Prof. Parvin adds whisky to the water in which it is bathed.

A case of aggravated dyspepsia with constipation was, by Prof. Da Costa, given:

R.	Tinct. capsici,	1 drop.	
	Tinct. nucis vom.,	8 drops.	
	Tinc. gent. comp.,	1 dr.	M.

SIG—Ter die. With gr. 1-5 aloin at bedtime, and avoid a starchy diet.

A young girl, aged 15 years, was shown to the class by Prof. Parvin, complaining of severe backache and constipation. She menstruated once every two weeks—was given quinine, gr. v daily, and arom. sulphuric acid, gtt. x twice daily; bran  $\frac{1}{2}$  oz. in water, at night, for bowels.

In the early stage of a case of pneumonia, Prof. Da Costa gave:

R.	Tinct. verat. virid.,	3 drops.	
	Liquor. potass. citratis,	3 dr.	
	Spirit. æth. nitrosi,	$\frac{1}{2}$ dr.	
	Syrup zingiberis,	$\frac{1}{2}$ oz.	M.

SIG—Every three hours.

In chlorosis, the following has often been of avail:

R.	Ferri sulphat. exsic.	2 scruples.
	Quininæ sulph.,	1 scruple.
	Strychninæ sulph.,	$\frac{1}{2}$ gr.

Ft. pil. No. xx.

SIG—One pil. three times a day—(Bartholow.)

In a case of locomotor ataxia, where the patient had been pretty thoroughly saturated with silver, Prof. Da Costa, to tone up the system, gave:

R. Syrup. hypophosphit,  
 Strychninæ,  
 SIG.—Ter die. 1 dr.  
 1-60 gr. M.

Prof. Bartholow says that for hæmoptysis "ipecacuhana is a remarkable physiological remedy." In a case at the clinic it was given in combination, as follows:

R. Ext. ipecacc. fluidi,  
 Ext. ergot. fluid, aa 5 drops. M.  
 SIG.—At a dose.

In cases of leucorrhœa, associated with granular vaginitis, Prof. Parvin uses for the latter condition nitrate of silver, combined with a tampon saturated with 1 dr. each of alum and bismuth. The tampon to remain twenty-four hours. For simple cases of leucorrhœa, he uses an injection of chlorate of potassium, 1 dr. to pint.

The following combination, Prof. Bartholow's, for asthmatic attacks, has been found very useful:

R. Ext. grindeliæ fluid., ½ oz.  
 Ext. lobeliæ fluid., 2 dr.  
 Ext. belladon. fluid., 1 dr.  
 Potassii iodidi, 3 dr.  
 Glycerini, 3 oz. M.  
 SIG.—Tablespoonful as required.

Prof. Parvin placed a woman with uterine fibroid, upon the following:

R. Ergotin., 1 gr.  
 Ferri sulph. exsic., 1 gr. M.  
 Ft. pil. No. 1.  
 SIG.—Ter die. Persistently used.

For the accompanying hemorrhages a tampon saturated with tinct. iodine or Monsell's solution.

A boy, æt. 18, a painter, was the subject of lead poisoning. Had great pain at defecation, etc. Was given, by Prof. Da Costa:

R. Ext. belladon. ½ gr.  
 Rhei, 2 gr. M.  
 Ft. pil.  
 SIG.—One morning and evening.

Also:

R. Pottassi iodidi, 10 gr.  
 Ter die, until lines on gums disappear.

—College and Clinic Record.

## ACUTE DYSENTERY.

Prof. Da Costa placed a man with acute dysentery upon a diet of arrow-root, corn-starch and broth; an opium suppos., 1 gr., morning and night, to which was added rest and:

R. Plumbi acetat.,	2 gr.	
Ipecacuanhæ,	$\frac{1}{4}$ gr.	
Pulv. opii,	$\frac{1}{4}$ gr.	M.

Sig.—Give every two hours until blood disappears, then lengthen the intervals.

## CONSTIPATION.

When there is atony or paralysis of the muscular coat of the intestines, belladonna is an especially valuable remedy. Five to ten drops of the tincture three times a day will often correct most obstinate constipation from this cause. The following prescription will be found serviceable where belladonna alone will not suffice:

Ext. belladonna,	2 gr.
Ext. nucis vomica,	8 gr.
Ext. aloes soc. aquos,	16 gr.

M. ft. pil. 16. Sig: One to four pills daily.

For nervous constipation the following is recommended:

Pulv. ferri sulphatis,	$1\frac{1}{2}$ gr.
Aloes socot,	$\frac{3}{4}$ gr.
Ext. belladonna,	$\frac{1}{3}$ to 1-6 gr.

One pill. One to four daily.

Dr. Bartholow prescribes the following in many cases of constipation with good effect:

Tinct. nucis physostigmatis,	
Tinct. vomica,	
Tinct. belladonna,	aa 2 dr.

M. Sig: Thirty drops, in water, morning and evening.

In habitual constipation, Dr. F. W. Pavy recommends the following pill:

Pillulæ rhei comp.,	2 to 3 gr.
Pulveris capsici,	1 gr.

To be taken with the food, and repeated daily, as occasion requires.

Dr. Horace Dobell says the following formula is one of the most satisfactory he has ever tried:

Podophyllin,	2 gr.
Essence of ginger,	2 dr.
Alcohol,	2 oz.

M. Sig: A teaspoonful at bed time, in a wine-glassful of water, nightly or every second or third night.

—*Indiana Med. Jour.*



# THE PEORIA MEDICAL MONTHLY.

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THOS. M. McILVAINE, A. M., M. D.,

*Editor and Publisher.*

204 S. JEFFERSON St., PEORIA, ILL.

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\*The Editor is not responsible for the statements or opinions of contributors.

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\*All exchanges, books for review, and communications must be addressed to the Editor and Publisher.

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## EDITORIAL.

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### OUR LAST EXPLANATION.

For the past three months the work of publishing this journal has been the hardest of its whole six year's history. Delay has been constant and inevitable, do what we could to prevent it; and our position was such that we could not make a sufficient explanation to our readers of its cause. The delay this month has been greater than ever before, but we feel happy to say it is the last of our tribulations in that direction. Our old printer was *financially embarrassed* and ended up in August by an assignment, which tied up the work on the MONTHLY until the *Transcript* Company could regain possession of the office. Then some scoundrel broke into the press room just when things were beginning to run smoothly again, and broke the presses and engine in such a way that a further delay was caused. Now, we hope, our trials are over and that next month (this month) we will be out on time.

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### THE PROGRESS OF THE WAR.

No severe engagement has taken place since our last report. but skirmishing all along the line has been the order of the day.

Circulars, pamphlets and letters are flying thick as leaves in Valambrosa, and charges and counter-charges, denials and re-denials fill up the correspondence departments in those journals most actively engaged.

Instead of waiting until next May, the New I. M. Congress Committee hold another meeting in New York to-day, thus "carrying the war into Africa" so to speak.

Dr. Davis has delivered some scathing rebukes to the recalcitrants, in the *Journal* of the Association, and he has been answered by the *Record, News* and others.

Some more appointees have withdrawn, the total number of withdrawals now being in the neighborhood of one hundred and fifty: Still with the couple of thousand members of the American Medical Association still remaining, it will not be hard to find enough to accept places in the Congress, to fill all vacancies.

### MEDICAL EXPERTS.

The *Chicago Tribune* thus pays its compliments to that class of physicians existing only in large cities, known as medical experts. It says: "Reil's form of insanity is classed by one medical expert as 'magnalomania.' If it were not for medical experts this world would be a dull place. Since the death of Artemus Ward's kangaroo they are, by all odds, the most 'amoosin' things in existence. They are so earnest too, with their theories, and their oroide classical nomenclature."

We wonder what the writer of the above would say, were he to run across a full-fledged, ardent, aspiring gynecologist.

### A GRAVE CHARGE CLEARED UP.

Judge Rodgers quashed the *capias* writ issued against Dr. John V. Shoemaker, of Philadelphia, at the suit of Henry A. Merritt, of Troy, N. Y., because the affidavit on which the writ was issued *was on information and belief, and not upon positive and undoubted knowledge*. In releasing Dr. Shoemaker's bail, the Court expressed his regrets at having granted the writ. Dr. Shoemaker is a well-known physician of Philadelphia, and was

charged by Merritt with having misstated the amount of money expended in taking his (Merritt's) sister with himself and wife on a European tour. The doctor maintained that he had done no such thing, but had rendered an account to Merritt for only so much money as had been spent. He claimed that Merritt did not state the facts positively, because they were untrue, and that the suit was brought for no other purpose than blackmail.—*Chicago Times*.

We congratulate Dr. Shoemaker on being acquitted of the grave charge made against him, and hope he will keep out of all sorts of trouble in the future.

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### MEDICAL ADVERTISING.

Doctors who want to break loose from ethics and advertise, should remember that unless they carry it to extremes, there will always be some who will make larger displays and thus get ahead of their less pushing competitors, and the modest advertisers will be just as bad off as they are now. "Dr." J. I. Lighthall is now in Peoria, with a brass band, singers, gymnasts, etc., and is said to be taking in over five hundred dollars daily. He has about twenty tents of various sizes, and a large audience tent capable of holding several thousand. He pulls teeth free, and since his stay here must have pulled a peck a day. He is certainly a very speedy extractor. He calls himself the "diamond king," wearing \$30,000 worth of jewels on his person. His watch chain of solid gold is as large as a trace chain; his watch is encrusted with jewels and is worth \$2,500. We mention these things to show what advertising means by a medical man, and to what an extent others must carry it before they can hope to compete with "diamond kings." We do not know by what right he practices, except that he pays a license of one hundred dollars a month.

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### A LAY EDITOR'S ETHICS.

We take the following "advice to a young doctor" from the columns of the *Brooklyn Eagle*, and reprint it as a curiosity. It contains some advice that is good, but also displays the usual lay ignorance of professional ethics:

THE HIGHEST AWARD,  
GOLD MEDAL,

Has been granted to

# MELLIN'S FOOD

FOR INFANTS AND INVALIDS,

*At the World's Exposition, New Orleans.*

**1885.**

---

Dolibar, Goodale & Co.,

*40, 41, 42 & 43 Central Wharf, BOSTON, MASS.*

---

*A Sample of MELLIN'S FOOD, Sufficient for trial, will be sent free  
to any Physician desiring it.*



**NON-ALCOHOLIC.**

**NON-RESINOUS**

**BLAND AND UNIRRITATING.**

# FLUID HYDRASTIS.

A definite and permanent solution of the Alkaloids of Golden Seal Root, viz:

**BERBERINA**—Of a bright yellow color, the salts of which are known in commerce as Sulphate, Muriate and Phosphate Berberina (Hydrastia.)

**Hydrastia**, crystallizing in white prismatic forms and insoluble in water.

**Xanthopuccina**, or the unknown third alkaloid, of a dark yellow color, but which has never been carefully isolated, and is unknown in commerce.

The use of **Fluid Hydrastis** is suggested in all affections of the mucous surfaces; correcting abnormal conditions characterized by profuse discharge of tenacious mucous, subcutaneous inflammation, erosions and superficial ulcerations.

## McDade's Prescription

—FOR—

**VENEREAL AND CUTANEOUS DISEASES.**

### FORMULA.

Fluid Ext. Smilax Sarsaparilla,  
Fluid Ext. Stillingia Sylvatica,  
Fluid Ext. Lappa Minor,  
Fluid Ext. Phytolacca Decandra, a a, two ounces.  
Tinct. Xanthoxylum Carolinianum, one ounce.

Mix—Take a teaspoonful in water three times a day before meals, and gradually increase to tablespoonful doses.

### CAUTION.

"In making the Fluid Extracts there is great risk of getting a remedy less efficient than the original Indian decoction, because the manufacturer may use roots that have been kept too long and lost some of their active principles; while the decoction used on the plantations was always made of Fresh Roots just gathered from the woods. In making the Fluid Extracts we should, therefore, be careful to have them made from roots recently gathered."

### REMARKS.

The WM. S. MERRELL CHEMICAL CO. of Cincinnati offer the formula of Dr. McDade, prepared in accordance with the principles so strenuously held by them for more than thirty years, viz., that the volatile elements of many plants are dissipated by the drying process, thereby injuring, if not wholly destroying, their medical properties.

**PRICE, \$12.00 per Dozen. \$1.25 per Pint.**

### Green Plant and other Fluid Extracts.—Merrell.

These remedies are positive Medicinal agents:—positive, not because they will invariably cure disease, but because their sensitive properties are definite, uniform and certain. Send for our paper on the subject of "Green Plant Fluid Extracts."

Agents for Peoria and Central Illinois.

SINGER & WHEELER,  
COLBURN, BIRKS & CO.,  
SUTLIFF, SHULTZ & CO.,  
ROBT. A. KING. } Peoria, Ill.

Do not be persuaded by foolish friends to plant yourself in any new quarter of the city. All new colonies are fatal to any early enterprise, the first settlers only clear the way for those who follow, and are regularly ruined for the benefit of posterity. When you have taken a house and put your brass plate on the door, you cannot do better than go abroad for four or five years. At your return you will probably find that no one has inquired for you, which must be very consolatory to your feelings, inasmuch as it will show you have lost nothing by your absence, and have yet given the world time to begin to ascertain there is such a person in existence as yourself. Having familiarized people with your name, it behooves you then to give it notoriety; therefore lose no time in getting into print. You cannot lay out a couple of hundred dollars to better advantage than publishing a pamphlet on any popular medical subject. A treatise on indigestion has gained many a physician a sumptuous dinner. Mott, Francis, Buck, furnish excellent examples of the sort of alchemy which transmits a grievous dyspepsia to a groaning table. "So many dishes," says Seneca, "so many disorders," but *vice versa* with the doctors, so many disorders, so many dishes.

The great majority of mankind are fools—that large portion you are to live by; therefore mystify your patients. When you talk to them, let it be in King Cambyses' vein. The ears of the million are easily captivated; when once their senses are confounded, they have naturally a reversion for anything they do not understand. In brief, in all your dealings with men, remember you have to do with folks who, according to the Latin proverb, "have all at some time been insane." Never give a direct answer to a patient's question, never commit yourself by entering into explanation with the friends. To the sick man you cannot put too few questions; to the relatives you can never give too few replies.

The great art of a physician is to gain the confidence of the patient, and for that purpose his first object should be to inspire him with hope. It is not a hesitating manner or a melancholy mien which is calculated to raise the drooping spirits of the sick; it is not a hangman's look or a mute's demeanor that is likely to lend the physiognomy of the physician the character of a mes-

senger of glad tidings, who comes with healing on his wings and the gift of health in his right hand; it is not the timid eye, the irresolute tread, the frivolous tongue, the fearful voice, or the foolish simper of servile acquiescence with the opinions of the friends or the prejudices of the attendants of the sick, which are at all favorable to the production of that faith which can remove diseases which have been mountains to mere medicine.

Never refuse a fee from any person who is able to give one, in order that you may never have occasion to take one from a man who is too poor to well afford one. It matters not how mercenary you may be accounted by the rich, so long as you are merciful to the poor. If you can not get fees without depriving them of bread, it were better you had never been a doctor. Your friends nor your familiars have any claim on your skill, whatever they may have on your affection. If they are entitled to your gratuitous attendance a large connection would be a great evil to a physician. Were you a merchant they would not ask your goods without an equivalent, and surely because you are a man of science they cannot expect the still more precious chattels of the mind without any compensation.

To obtain practice be sure to enlist the service on your side of the pastors of all denominations in your neighborhood, and pay your court assiduously to the influential women, but above all, if in the country, to the one or two charitable ladies, *par excellence*, who are to be found in every town, devoting a life of single blessedness and all the leisure of neglected beauty and imperishable celibacy to the service of religion and humanity. Be sure that buy golden opinions of these good women, for with all their active benevolence they have a large portion of their leisure to bestow on the privacy of their friends and neighbors, and heaven defend the reputation of that poor wretch who, at the terrible Areopagus of their tea table, is consigned to the tender mercies of their envenomed tongues.

Avoid the society of your patients. Physicians should have no familiars; to be thoroughly respected, they must stand aloof from the gaze of society. A prophet has no power in his own country, neither has a physician in his own circle. Without skill it is impossible to become a flourishing physician, but without

good manners all the skill of the most eminent physicians will not avail you in a large capital. A good address is everything to a doctor. The public are incapable of judging of a medical man's real knowledge; the only way they have of forming an opinion, therefore, is by analogy, by scrutinizing those superficial qualities and the outward and visible signs of them, which come immediately within the narrow sphere of their comprehension. If his manners be good, they give his mind credit for the advantage.

The last and greatest precept of all is: Never violate in thought, word or deed the sanctity of the sick chamber! He is a villain who reveals the secrets of that prison house, where pure humanity lies bare and helpless: he is a traitor to his profession who gossips about the infirmities he is called to relieve; he is unworthy the name of a physician who, abusing the confidence which is reposed in his humanity and his honor, has no sooner turned from the bedside of the patient than the infirmities he has witnessed become the subject of a ribald jest.

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The Mississippi Valley Medical Society will meet in Evansville, Ind., September 8th, 9th and 10th. This is the second largest Medical Society in the country and is always largely attended. It has no constitution, or by-laws, and its sessions are given up entirely to legitimate business.

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The Illinois State Board of Health is now engaged in revising the "Official Register of Physicians and Midwives."

Any notification of changes, omissions, or errors will be regarded as a favor, as the Board wishes to make the coming register as near correct as possible. Address, Secretary State Board Health, Springfield, Ill.

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Dr. John Ten Brook of Paris, Edgar Co., Ill., died at his home, August 8, 1885, aged 77 years. Dr. Ten Brook was one of the oldest practitioners in this State; he was a graduate of the Jefferson Medical College in 1838, and had practiced in Illinois for about 48 years.



## BOOK NOTICES.

ELEMENTS OF MODERN MEDICINE—Including Principles of Pathology and Therapeutics with many useful memoranda and valuable tables for reference. Designed for the use of Students and Practitioners of Medicine.—BY R. FRENCH STONE, M. D., Professor of Materia Medica, Therapeutics and Clinical Medicine in the Central College of Physicians and Surgeons, Indianapolis, Ind., etc., etc. 12mo; pp. 368. Leather, tucks. D. Appleton & Co., New York. 1885.

As stated by the author in his preface, "The design has been to not only present in a regular and systematic order, the general principles of pathology and therapeutics and in the light of present knowledge to harmonize these principles with one another, but to simplify and to facilitate their application to the investigation and management of individual cases."

Apart from the small size of the type used, we have no fault to find with this work. It admirably fills the design of the author as a text-book for the use of students, and as a ready reference book for the use of practitioners. The author is evidently a man not only of fine education, but also a practical man, and we venture to say a competent teacher and successful practitioner. A book written by a man of this kind is always worth reading and a place for frequent reference. This volume is of convenient size and shape to carry in the pocket, and we doubt not will have a handsome welcome.

POISONS—THEIR EFFECTS AND DETECTION. A manual for the use of analytical chemists and experts. With an introductory essay on the Growth of Modern Toxicology.—BY ALEXANDER BLYTH, M.R.C.S.F.C.S., etc. With tables and illustrations. Cloth, 8vo; pp. 334. Vol. II. Wm. Wood & Co., New York.

The first volume of this standard work was noticed in the June issue of this journal. This volume completes the work.

ON RENAL AND URINARY AFFECTIONS. MISCELLANEOUS AFFECTIONS OF THE KIDNEYS AND URINE.—BY W. HOWSHIP DICKINSON, M.D., (Cantab.), F.R.C.P., etc., etc. Cloth, 8vo; pp. 343. Wm. Wood & Co., New York. 1885.

This work is the second of a series on Diseases of the Kidneys by this distinguished clinician and author; the first of which, a treatise on Albuminuria was printed in *Wood's Library of Standard Medical Authors* for 1881. The position of Dr. Dickinson as an authority on renal diseases is such, that any work from his pen is at once accorded a high rank in medical literature. Treating as it does of a variety of different diseases of the kidneys, this volume is one of the most practical and generally useful that *Wood's Library* has yet given us.

A TREATISE ON EPIDEMIC CHOLERA AND ALLIED DISEASES.—

By A. B. PALMER, M.D., L.L.D., Professor of Pathology, Practice of Medicine and Clinical Medicine in the College of Medicine and Surgery in the University of Michigan. Author of a work on the Science and Practice of Medicine, etc., etc. Cloth, 12mo; pp. 224. Register Publishing House, Ann Arbor, Mich. 1885. \$1.00.

This publication, so timely in view of the possible visitation of epidemic cholera in this country, consists of a volume of about 200 pages, neatly and substantially gotten up, and bound in cloth. It contains a summary of the literature on the subject brought down to the present time, including the recent investigations of Koch and others; and in it the causes, methods of prevention and treatment are fully discussed, and definite directions given.

The reputation of the writer as a practitioner, teacher, and writer, and his large experience in cholera during three seasons of its prevalence in Chicago, is a guarantee of the character of the work.

THE TECHNOLOGY OF BACTERIA INVESTIGATION. Concise direction for the study of bacteria, their culture, staining, inoculation, mounting, etc., according to the methods employed by the most eminent Microbists.—By DR. C. S. DOLLEY. pp. 263; 12mo, Cloth. S. E. Cassino & Co., 41 Arch St., Boston, Mass. Price \$2.00.

There is nothing as yet in English, or in any language, that gives the physician and investigator the methods employed by such men as Pasteur, Koch, Erlich, Weigertz, etc., and it is believed a book giving concise directions where to look for and

how to study the different forms, especially those having a pathogenic significance, will be gladly welcomed, especially at this time when there is such widespread interest in the etiology of certain infectious diseases. It is also hoped that the publication of this work will stimulate original work among American investigators in this department, as heretofore by far the greater amount of the work has been done by European. The following is a summary of the work:

General Introductory Remarks.

Chapter I. *Microscopical Preparations*.—(1) Study of living forms; (2) Study of fixed forms—(a) without staining, (b) by staining; (3) Methods of making preparations of the Bacilli of Anthrax, Glanders, Hog Cholera, Lepa, Septicæmia, Tuberculosis, Typhoid Fever, the Micrococci of Gonorrhœa, Infectious Myelitis, Pneumonia, Rabies, etc., according to the methods of Weigertz, Kaatzer, Koch, Babes, Baumgarten, Erlich, Flugge, Rindfleisch, Gibbes, Frankels, etc.

Chapter II. *Study of Bacteria by Culture*.—(1) Culture vessels; (2) Culture media; (3) Introduction of media into culture vessels; (4) Sowing microbes in culture media; (5) Carrying on the culture.

Chapter III. *Vaccination Method of Studying Bacteria*.—Bacillus Anthracis, Chicken Cholera, Bacillus of Tuberculosis.

Chapter IV. *Study of Bacteria by Biological Analysis*.—Engelmann's method; Metschnikoff's method.

Chapter V. *Formulae*, etc.

SECOND REPORT OF THE STATE BOARD OF HEALTH OF THE STATE OF TENNESSEE, OCTOBER 1880 TO DECEMBER 1884. Cloth, 8vo; pp. 600. A. B. Tavel, State Printer. 1885.

This report contains many valuable papers on subjects relating to hygiene and sanitary matters. The gentlemen comprising the Board are active and energetic and take a lively interest in the sanitary affairs of their State. The Report is well gotten up and finely indexed.

TRANSACTIONS OF THE LOUISIANA STATE MEDICAL SOCIETY.—At its Seventh Annual Session held at New Orleans. 1885. 8vo; paper, pp. 184.

Contains many interesting papers. As usual in such cases the President's address is the longest paper in the volume. The article on Hemorrhagic Malarial Fever is worthy of especial note.

### OUR ADVERTISERS.

The advertising department of a medical journal is by no means the least important. What would a newspaper be worth without advertisements? A physician who keeps himself thoroughly posted, must read the announcements of medical houses in his journal. All notices made in the reading pages of this journal are made of our own accord, without pay, for the triangular benefit of our readers, our advertising patrons and our journal. Nearly all of our advertisers will forward samples of their goods to physicians if they mention the **PEORIA MEDICAL MONTHLY** in the request.

**JOHN WYETH & Co.** claim absolute accuracy of dose, ready and entire solubility and perfect preservation of the drug, for their Hypodermic Tablets. A full list will be found on page 15. We have tried them and know them to be perfectly reliable.

**H. PLANTEN & SON**, 224 William street, New York, established 1836, the well-known manufacturers of capsules for medical use, are introducing to the medical profession, druggists and the public, several new kinds of their excellent *Filled Capsules*. Besides their so-called "black" capsules (com. cap. and oil of cub.), and other standard kinds, which in quality, size and price are unsurpassed by any other brand in the market, they now offer pure East India sandal wood oil, either in *hard* or *soft* capsules, and recently *oil of wintergreen*, which, in rheumatism, is regarded as a specific by the medical profession. This firm was the first to introduce that so highly valuable article *empty capsules*. They have improved their manufacture in such a degree that their brand maintains its old high place among the best. They offer now the largest variety and are the cheapest in the market.

**THE New York Pharmacal Association** wish to call your attention to their advertisement on page 2, in which they claim to have the most important remedial agent ever presented to the profession for dyspepsia, vomiting in pregnancy, cholera infantum, constipation, etc.

**NERVOUS PROSTRATION AND BRAIN TROUBLES.**—For some time past I have used *Celerina* in my practice. I used it first in a case of *nervous prostration* and found it a success when other remedies failed. Would recommend it in all nervous diseases or brain troubles. I find it soothing, lasting and permanent in its effects, and in many cases of nervous debility and loss of *will power in certain directions*, produced by indiscretions, etc., I consider it an invaluable remedy.

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P. MCA DA 2



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Williamsburg, Miss.

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Others will be mentioned in following numbers, also other articles of value, even if they are not advertisers.

## RECEIPTS.

The date following each name, indicates where the amount credited extends the subscription:

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## ORIGINAL COMMUNICATIONS.

### THE CAUSE OF IMMUNITY IN DISEASE.

BY DR. ROMAIN J. CURTISS, JOLIET, ILL.

In the July number of the MONTHLY, I proposed the doctrine of natural selection as the explanation of the fact of immunity in disease, and signified my intention of considering the other theories that have been advanced to explain the various phenomena which belong to contagion and immunity.

"A Writer," I am pleased to see, feels an interest in this subject sufficient to give me a review in the August number. On reading his paper I am happy to agree with him on a few of his points, viz: "Scientific phrases have a lovely and captivating sound;" "Any physician of experience could give a very good guess as to what persons would be likely to be affected by different kinds of weather;" "When certain diseases are rampant (what is rampant, anyhow?) we fear for the constitution of certain persons;" "Given the color of the hair, eyes, skin, the chest, abdominal and head measurements, their place of birth, sex, age, residence and occupation, and a little of their personal history, and it is not hard to forecast their morbid future."

I suppose the above "aphorisms" are not "quasi-scientific," but I can't see what relation they have to the immunity in disease. It appears that the writer does not either, but a little further on he proposes his theory for all the phenomena of immunity, in these words: "The eternal fitness of things."

Now that the matter has been satisfactorily decided, it would appear to be useless to consider it further, but as this explanation of the "eternal fitness" must come up in conflict with other theories that have been proposed, I may as well bring up the other theories and compare them with the theory of natural selection, and with this later "corruscation of brilliance" the theory of the "eternal fitness of things." I wonder if we can class phenomena as well as things under this head?)

I must premise, however, that I am sorry to have brought up easy cases of variation and atavism, which are really "not Darwinian." The adjuster of "eternal fitness" in medical matters thinks that the callous formed on the hand by rowing a boat and its subsequent removal is not a variation and an atavism. Well, I am willing to admit that it belongs to "eternal fitness" (no use disputing small points), but I rather think that the whole process comes under the head of physiological variations and atavism also. The combat of the cells of the skin with the oar certainly produces a variation in the form, size, number and enlargement of the cells, the object being to enable the skin to endure friction. Now, when the cause of this variation has been removed, this variation necessarily changes—the skin resumes the form it had before. This change is physiological atavism, or else there is no such thing as atavism.

By the use of this special instance, I did not expect to illustrate the whole phenomena of variation, atavism, and hereditary descent, or explain all there is in natural selection. I used the special instance for all it was worth and no more. It may be a better explanation to say that a callous forms on the hand by rowing a boat, and afterwards goes off again by the "eternal fitness of things," but though this explanation bears the stamp of science and devoutness, it is "hard" to understand.

But our reviewer thinks natural selection can't explain the facts of immunity in disease, because it is too slow in action. Natural selection, he quotes, is slow, and "*will soon banish the belief of any sudden or great modification of structure.*" This is all true, I suppose, except as natural selection acts upon belief, and it is for this reason that natural selection is capable of explaining the immunity in disease.

Many centuries of time have elapsed since history gives us an account of disease. This history tells us about the great epidemics which overran Europe in the middle ages. History tells us about their rise and fall, and that they declined to all appearance spontaneously. If it were not true that natural selection acts slowly, it could not explain the decline of the great epidemics, but I hold that it does explain their decline. It may be possible that if our scientific and devout reviewer had been in Europe during the middle ages, and had measured the people's " chests and abdomens," and noted the " color of their eyes and hair," that he could have prophesied, from these data, just when the epidemics would decline by " eternal fitness," but as these data are not at hand now, I have the honor to suggest the slow-going law of natural selection as the explanation.

But the real animus of our critic's remarks appears to be his assumed devoutness. He says, " No half-way developed animals are found in the earth alive." " Moses is said to have made mistakes," " but so far science is with him, and God saw everything he had made, and behold it was very good." From this remark I infer that the critic thinks natural selection is " quasi-science," and don't believe it anyhow. He reminds me of another alleged devout man who lived in the times of Copernicus, and who believed the world was round, not because " Moses made mistakes," but because " in the second coming of the Lord the people who lived on the other side couldn't see him come." It may be that one of the things the Lord saw and pronounced " good" was the general biological law of natural selection, and He no doubt made the world round and called it " good." At any rate the people who are looking for the second coming do not appear to be disturbed by the spherical character of the earth. But our critic now turns over, and like a restless sleeper, lies on the other side awhile. He says that " it is not to be wondered at that continued exposure to destructive agencies may result in such changes of tissues as to secure entire immunity. When exposure ceases it is not unreasonable to believe that they return to their normal condition." Now I can put no other construction upon these propositions than the admission of the doctrine of natural selection. Of course the



language is ambiguous, and I don't know what is meant by "destructive agencies," but I suppose the writer chooses an ambiguous method to escape being "sonorous," or "quasi-scientific," or "giving a title to an essay," or a "dogbite," or some other original elegance of expression.

But in addition to the doctrine of "eternal fitness," and that of natural selection, are one or two more which have been suggested to explain the immunity from disease. The first of these is based upon a peculiar property or physiology of bacteria, which is that the physiological waste of a given species may act as a poison to another given species, and also to the same species. An instance may be given by the well known fact that the yeast organism will live and prosper in a mixture of sugar and water, and consume it, and convert the material into alcohol—the alcohol being the physiological waste product of the yeast organism. Now the yeast organism cannot live in alcohol, its own waste product, and many other organisms cannot either. In fact, there are no species of living organisms known which can live in their own waste products, except the citizens of Chicago, who seem to prosper by drinking their own sewage. The theory of immunity, based upon this fact is, that the organisms of disease leave their waste products in the tissues of the diseased person, and the result is that other colonies of the same disease organisms cannot exist in the same person, by reason of the presence of these waste products in the tissues. This is theory one. The theory rests of course upon the assumption that the waste products of the micro-organisms do stay in the tissues, but is not proven because these products ought to be found, if they are there, and they never have been found.

Theory No. 2, is based upon the diet question. It assumes that different species of bacteria have an affinity for certain tissues as a diet. When the organisms of a given disease attack the body, they consume all the tissue to which they are "adapted in the eternal fitness of things," and consequently the person has an immunity from this disease until the tissue is repaired.

This theory rests upon the assumption that certain tissues in disease are entirely consumed, or at least certain chemical constituents; but if this were true the microscope would cer-

tainly be able to demonstrate the fact, which has not been done.

Theory No. 3, is called the oxygen theory, and was proposed by Dr. Salmon. It assumes that the microbe gets into the body of man by accident, and not as the final result of natural selection in its development, or adaptation, or the "eternal fitness of things." (This fitness reminds me of the doctor who could cure anything by changing it to fits, then curing the fits.) But Salmon's theory assumes that the organisms of disease, after first getting into the body, are obliged to defend themselves, which they do by taking the oxygen away from the tissue cells, whereupon the cells become asphyxiated and fall an easy prey to the microbe. The theory, then, assumes that the cells acquire a resistance to the microbe from the experience gained by conflict, and that this experience enables them, the next time, to prevent the microbe from taking away their oxygen.

Now, there are two or three conditions of things which interfere with this theory. In the first place, there is no uncombined oxygen in the tissues; all such oxygen exists in combination. Salmon's theory, which assumes free oxygen in the tissues, can't exist where there is no free oxygen. Another fact in the way is the known action of the microbe in killing its prey, the cells, by poison, instead of by robbing them of oxygen. Besides this, Dr. Salmon, in order to show the relation of his theory to immunity, says that the cells acquire, by conflict with the microbe, a successful resistance. Now, acquiring a successful resistance, in this manner, is just what is claimed for natural selection. The cell acquires a variation by this conflict, but the variation does not enable it to consume its own oxygen in spite of the microbe; it enables it to resist the poison of the microbe. Natural selection assumes that when this process has been repeated often enough and long enough, in relation to an epidemic cause and the subjects of the epidemics or diseases, that the tissue cells will acquire a physical resistance to the action of the poison of the microbe, which shall be a successful resistance. The people who have acquired in this way—by actual conflict with the microbe—a variation of cells and physical resistance to poison, by hereditary transmission of these powers, represent the people thus naturally selected by the law of natural selection,

as being the fittest to survive, at least so far as their relations go to this particular microbe.

To conclude, I wish to say that, of course, I do not claim any originality in the application of the law of natural selection to the immunity from disease, no more than my critic would claim originality were he to cipher out the orbits of the moons of Mars by the law of gravitation. The matter was suggested to me as the possible solution of the question, because natural selection is as much a law of life as gravitation is in physics, and there is, therefore, no way of avoiding the explanation of immunity by this method. I will say further, that however short I may be in a knowledge of the law of natural selection, or of gravitation, or of the "eternal fitness of things," that this assumption can make no difference with the true relations of immunity in disease and natural selection. I would like to see the subject discussed in a gentlemanly way, as I tried to discuss it without blackguarding anybody, and by men who are capable of thinking in a scientific manner, but can so divest themselves of theological dogmas that they are not afraid to look at something round for fear that the world after all may happen to be a sphere, and the Lord may call for them when it is daylight for the heathen Chinees and a little dark in Illinois.

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## PERISCOPE AND ABSTRACT.

### COUGH.

In this day of physical examination of the thorax some other matters have almost dropped out of sight. The old physician who recently declined the loan of a stethoscope by a young clinical assistant for the diagnosis of pneumonia, saying, "Thank you, young man; but I think I can detect pneumonia without a stethoscope!" could no doubt have taught that youth much that would be useful to him. A stethoscope is a capital instrument in the hands of a man who knows its use; but it has undoubtedly drawn attention away from what may be termed rational consideration of the chest, and a judicious handling of what the patient has to tell, which often furnishes a clue to the treatment; a matter on which sometimes the stethoscope is silent. It is not that physical examination is not a most valuable means of acquiring certain information; but that this other information is



apt to be overlooked or underestimated; and thus a good proportion betwixt the two means of examination is lacking.

A cough is a forced expiration to eject some offending material from the air-tubes, just as a sneeze clears the nares. But suppose the offending or irritant matter can not be ejected, what then is the value of the cough? Nothing whatever. There is, then, much useless cough, as well as useful cough. Other matters than something in the air-tubes may set up a cough. Thus we find cough equally present when there is some phlegm in the air-tubes; when there is a mass of tubercle undergoing softening; and in the pulmonary congestion of a mitral lesion. A crumb in the larynx will provoke violent cough; and so will other laryngeal irritation. All know the brazen trumpet-like cough of aneurism of the aortic arch pressing upon the recurrent laryngeal nerve, a cough closely simulated in character at times by a neurosial cough. This last was so marked in two girls that their cough told when they were on the hospital premises. It is needless to say their departure was always expedited. Then, cough in the form of "hawking" is exceedingly common in pharyngeal disturbance.

There is, too, cough unconnected with the air-passages and the respiratory organs. There is the well-known cough of pregnancy, the "nine months' cough." There is ear-cough, said to be connected with the tympanic branch of the glosso pharyngeal nerves, which is set up by irritation in the ear. There is the cough of gastric irritation, common with alcohol indulgence. In one case, at least, known to me, diarrhoea always set up a cough. Cough of the "hemming" character, often misinterpreted as the short cough of early phthisis, is found commonly in girls at or after puberty, linked with ovarian or spinal irritation. It is clear, then, that cough has various causal associations.

The importance of reflex cough need not be considered here; nor yet the means by which it may be relieved. In all reflex actions the bromides suggest themselves at once. If the exciting cause can be dealt with, then the resultant cough is relieved.

It is rather the intention here to consider cough from its clinical and therapeutic point of view, and to see what indications it furnishes us for treatment. For instance, in "heart cough," *i. e.*, where the cough—a hard, dry cough—is set up by congestion of the pulmonic or lesser circulation by some dam or block at the mitral ostium, sedatives are more undesirable.

Such cough is most commonly found in a young girl with mitral lesion. One such case I well remember when the resident medical officer of the Leeds Public Dispensary. The girl, a child of twelve, had mitral regurgitation—an injury inflicted upon her previous to her coming under my notice. Digitalis and



iron improved the general condition, and with it the amount of cough; but still the child, a bright neurosal creature, coughed considerably. She ceased to attend, but some weeks later her mother came and made a frank confession to this effect: "Doctor, I thought the girl ought to have some cough medicine, and when I asked you for it, you always refused to give her any. One day I came when I knew you would be out, and got one of your assistants to grant me some cough stuff. It acted like a charm; but she soon fell off and lost her appetite, and could not get about; and now there is dropsy in her ankles. She is so bad, I want you to do what you can for her." Appropriate treatment soon restored the child to her ordinary condition; but her mother did not hanker after cough medicine after this experience. This case illustrates vividly the disastrous effects of allaying the cough when due to pulmonary congestion. For a little time it gave relief, but the after condition was worse than the first. So much for the indication afforded by cough under one set of circumstances, the case just mentioned by no means standing alone.

The consideration of "useful" and "useless" cough may now engage our attention. It is a matter involving the gravest thought, and well deserves our best consideration. We will take cough in bronchial cases first. There is in the early stages of acute bronchitis much useless cough set up by the dry mucous membrane, and the means for its relief have been set forth in a preceding article ("Bronchitis, Acute and Chronic"). Then it was said there existed no particular objection to opium, which gives great relief. But in such case the sedative is combined with other agents of a relaxant character, as tartar emetic or aconite. As soon as free secretion comes the cough changes its character. It is no longer the dry, harsh, shaking cough of ineffectual effort, raising nothing, but becomes the less painful, truly expulsive cough of successful effort. Now, what we are required to do is to give stimulating expectorants, and so help and improve the character of the expulsive cough. There is usually at this point no indication for opium, and none is required unless it be a little at bedtime in certain cases.

It is rather in chronic bronchitis with little expectoration and much bronchial irritation that the question of decision taxes our best mental energies. In some cases the rest at night is broken by irritant cough, and then the question arises of the lesser of two evils. If the opium arrest the secretion, and so render it tougher and more difficult to get up; if the opium brings lethargy to the liver, impairing the appetite, and locking up the bowels, still it gives the patient rest. Consequently it may become necessary to administer it. But it should be given

with benzoic acid in compound squill pill, and a little pōdophyllin or watery extract of aloes to counteract its undesirable effects in the alimentary canal. And by such combination no doubt the maximum of good with the minimum of bad effect can be secured. Numbers of chronic bronchitics under my father's professional care took such a pill every night for two years without apparent injury, while it added greatly to their comfort. (I refer to my father's experience in these cases because I served under him and saw his practice, my own experience of general practice being short.) But granting all this, the less opium in disease of the respiratory organs the better—as a broad rule. Sometimes some chloral, or bromide of ammonium with tincture of hyoscyamus, may seem indicated rather than opium, or even may be the best agent to employ in certain cases. But, in a general way, opium (in such pill combination as has just been suggested), with some alcohol at bedtime as a "night-cap," *i. e.*, whiskey or brandy and hot water, taken on getting into bed, is the best practice with chronic bronchitis. One great matter there is in such cases, never to be lost sight of by the patient, and that is to avoid passing from a warm sitting-room to a cold bedroom; the bedroom should also be warm. Another is to have the bed warmed by the old-fashioned warming-pan, or, perhaps better still, by a hot-water bottle, which can be pushed down to the foot of the bed (so as to keep the feet warm) when the patient gets into bed. This matter of an equable temperature is very important, and many bronchitics toast themselves well before going up stairs to a cold, unwarmed bedroom, where they cast off their day clothes, don a cold night-shirt or gown, as the case may be, then kneel down and say their prayers, and get into a cold bed. It is needless to say that no medicinal course can be successful in a case where this goes on.

Important as the matter of cough and its indications for treatment are in chronic bronchitis, the matter of cough in chronic pulmonary phthisis is even still more important. There is the cough in the night breaking the sleep, and there is the cough in the day shaking the sufferer; both objectionable and undesirable, and requiring to be dealt with. The circumstances under which cough is developed in pulmonary phthisis vary. Sometimes mere apex consolidation is accompanied by cough. Where there is bronchial implication and localized bronchitis in the affected area this can readily be understood; but at times there is cough without the moist rales indicative of this condition. We are compelled here to suppose some irritation of the pulmonary fibres of the vagus, which is transmitted to the respiratory center, leading to a discharge producing the modified inspiration and expiration familiar to us as "cough." Belladonna

is said to exercise a decided influence over these fibres, and so is indicated in such condition. (By this property belladonna, or atropine, is a desirable addition to an opiate for a night-pill.)

It has also been claimed for *gelsemium sempervirens* that it is useful in such cough by its action upon the nervous mechanism of the respiration. Bromide of ammonium suggests itself at once for the relief of such cough, from the known utility of the bromides in all reflex trouble.

One curious point there is about cough in its relations to static pulmonary consolidation, and that is this: Whenever a person possessed of a patch of consolidated lung has also the liver upset, then the irritation in the said patch with resultant cough is marked. No cough medicines nor antispasmodics do any good; but agents which act upon the liver, as a blue-pill at bedtime (or other mercurial), and a dose of sulphate of soda next morning, produce a distinct and unmistakable effect in lessening the cough. Consequently, when a patient complains of troublesome cough and an area of consolidated lung is found, it is often well to inspect the tongue and inquire into those subjective sensations experienced when a person is bilious or "liverish." From its known effect upon the liver, opium not only gives no relief, but positively aggravates the condition.

When a tubercular mass, or a portion of the consolidated area commences to soften—probably by the proliferating cells being so crowded on each other that they die; possibly by the appearance of bacilli on the scene—then we can readily understand the oncome of cough, and often severe cough. The dead mass is an irritant—like the thorn of Van Helmont—as a process of ulceration cuts it off from the surrounding lung-tissue; and during the time the process is going on there is distinct local irritation setting up the cough. There is, too, hectic fever, with nocturnal pyrexia and night-sweats. In this condition it may become necessary to add some opium or morphia to the mixture of quinine or phosphoric acid so much in vogue for its relief; and whether any sedative must be added or not; and if so, what quantity is a matter to be decided by the merits of each particular case. That some morphia is unavoidable to procure sleep in such condition goes without question; but it must be guarded by the additions suggested in the article on "Pulmonary Phthisis." Such a condition is like a specific fever, or a storm at sea, in that it comes to an end sooner or later, and if the organism can be kept going, or the ship afloat till the end comes, all is well. Of course if there be but one softening patch the irritation set up is smaller than when there are several such morbid areas. In the latter case, opium in the day may be unavoidable; and its drawbacks must be met and got rid of, or neutralized, by such wit



and skill as the medical attendant can command, either in himself or in some consultant of more experience or deeper thought. Above all things, keep up the powers by such food as the patient can take. The fever usually brings with it thirst. Then let the patient have cold beef-tea, with baked flour in it; malt extract, with effervescing water; milk, with a mineral water or whey; or milk diluted with water, and some Mellin's food added; and good home-made lemonade, with a fair amount of acid and sugar or malt extract in it. Rice-water, or barley-water, or tamarind water may be relished. Grapes and the juice of fruit are excellent. Alcohol may, too, be indicated. Sometimes it is neck or nothing. The patient must be heavily dosed with opium to allay the paroxysms of cough; aye, and there is something more than a cough, viz., the danger of hemorrhage from a ruptured blood-vessel in the softening area, brought about by the violent effort of cough. The poor patient is like a soldier with the bullets flying over his head; if he escapes one, another hits him. The patient is passing through a period of acute perils; perhaps rather, he is like a canoe shooting rapids stuffed with rocks; much, very much depends upon the boatman's skill and experience; something upon luck—and the patient's luck is the luck of a good constitution! If the softening areas be numerous or extensive, then the prospects of escape is small, and the skill of the steerer will be gravely taxed. In spite of everything that skill and assiduous attention can do or accomplish, the case may go on from bad to worse unto the inevitable end.

But, in my own experience of phthisis, cough has not been so very prominent a matter as to require treatment in the day, except in a few instances. It is not common for the consumptive to be shaken by racking cough requiring opium in the day. And on inquiring of an experienced sister at the hospital, who has watched the practice of many physicians, including the late Dr. Peacock, she informs me that my personal experience is in harmony with that of other physicians at Victoria Park Hospital. It is at night that cough is prevalent; and the use of opium, in combination with other agents, to procure a good night for the phthisical is a matter upon which there is general agreement.

When there is one or more cavities present, the use of opium is not affected by the fact. Indeed, a cavity is a matter of little moment, either one way or the other, therapeutically. Of course, the patient is no better for having a cavity; but the question is, Is he any worse? Patients with cavities die, certainly; and patients with cavities leave the hospital very greatly improved by their stay. As to the question of cough and its treatment, a cavity counts for nothing; the cough certainly may be connected with its contents, or perhaps the condition of its



wall. But the fact of the patient being in the third stage of phthisis (following the classification of Pollock in his "Elements of Diagnosis in Phthisis") does not affect the treatment.

Finally, in dealing with cough, the physician may observe and reason upon the cause of the cough, what it accomplishes, and how it affects the patient, before proceeding to deal with it. Some cough is useless, because ineffective, and needs some stimulating expectorant to render it efficacious—a very common affair; some cough is useless from every point of view, and so requires a sedative; and here the physician must decide in each case which is the lesser of two evils—the cough or the sedative.—*J. Milner Fothergill in Med. Record.*

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### FRACTURE OF THE NECK OF THE THIGH BONE:

The frequency of its occurrence, the gravity of its often arising complications, and the rarity of its satisfactory repair, gives never failing interest to the consideration of fracture of the neck of the thigh bone.

Occasionally met with in middle life, possible even in childhood, it is one of the common accidents of old age. For this there is good anatomical reason in the increased brittleness of the bone; dependent not, as was long held, upon an altered proportion of animal and inorganic matter, but upon senile rarefaction. As the active period of life passes away, the cortical compact layer of the neck becomes thinner, its trabeculae (that like pointed arches so marvelously support weight and transmit shock) more and more disappear, and the interseptal spaces correspondingly increase. The neck settles down, and its angle with the shaft diminishes—more in women than in men, and hence the greater frequency of the accident in aged females. Very possibly the ligaments of the hip actually as well as relatively, increase in firmness, and the bone yields rather than its fibrous investments; fracture takes place, not dislocation. Muscular atrophy, by removing one of the protective forces, contributes its share to putting the parts in condition to be injuriously acted upon.

Where may the break occur? Anywhere between the head and the inter-trochanteric lines; the degree of obliquity of the feature depending in part upon the structure of the neck, but in great measure upon the direction of the breaking force, usually a blow upon the region of the great trochanter or the thigh just below.

The literature of the profession is full of discussion, at times acrimonious, upon the intra and extra-capsular fractures; their

relative frequency, their differential diagnosis, their appropriate methods of treatment, and their resulting repair. But practically all this is of little or no value. It is impossible in any given case to determine, except by *post-mortem* examinations, whether the fracture lies wholly in or partly without the capsule; for only upon inspection of the joint can it be known just where the capsule posteriorly blends with the synovial membrane. Anteriorly, it normally comes down to the inter-trochanteric line, but upon the posterior surface it may stop well up toward the head, or approach quite closely the line joining the trochanters. In other words, all neck fractures are intra-capsular in front, but behind some are and some are not; and I know of no way in which, during life, the one class can be absolutely diagnosed from the other. Just here lies the little or no value of all specimens of assumed bony union, which are unaccompanied with their capsular ligaments left *in situ*. The wise course, therefore, it seems to me, is to stop with the determination of the existence of a neck fracture; and to treat all cases as if complete repair by bone might naturally and properly be expected, and in such way as to secure the desired result with least discomfort and risk to the patient.

As we all know, the cardinal principles in the treatment of any fracture, are to place the fragments in apposition and to keep them there; and the careful, faithful attention to these principles in the great majority of cases, results in satisfactory union, without regard to the age of the patient or to the bone broken. Why, then, is this neck fracture so generally recovered from with a fibrous union, shorter or longer, and at times followed by entire want of repair? Because (it is commonly held) of the very limited blood supply to the upper fragment, the comparatively small area of the surfaces of the break, and of the constant presence of synovial fluid bathing the ends of the fragments. But if the amount of blood carried to the head and neck is sufficient for growth and maintenance in a state of health, it surely ought to be enough for repair; even if there is no increased afflux to the damaged part because of existing irritation and inflammation, as there must of necessity be.

In all other parts of the skeleton, the mere superficies of the fracture surface does not make for or against proper consolidation; and besides, the area in the fracture under consideration is not very small. In fractures involving other joints, though synovial fluid in excess is present, still firm union takes place. Even if the alleged causes of failure are operative, they can be so only to a limited extent, and they must be regarded as very largely insufficient to produce the result which is generally effected. What then is it that, either alone or in connection with defective

nutrition and excessive secretion, causes the ordinary imperfect repair of neck fracture? To what is due ligamentous union or non-union in fractures of other long bones? Chiefly, usually wholly, want of proper apposition of the fragment and failure to keep them quiet—one or both. Why is not the same thing true when it is the cervix-femoris that is broken? Let impaction occur at the time of the accident, and let it not be broken up by injudicious manipulation or by inflammatory softening, and repair takes place readily enough, and the patient ultimately has a useful limb; more or less shortened, more or less everted, but nevertheless a good limb upon which to stand and with which to stand and with which to walk. Why? Not because more blood is carried to the parts, not because the synovial fluid is kept out from between the pieces, but because these latter are held in firm apposition. Experimentally pin the two parts together, as Senn did, and complete repair will follow. In the unimpacted cases treated with a long splint, muscular action is constantly tilting or sliding the fragments: the weight of the body resting upon any ordinary bed is crowding the pelvis, and with it the upper fragment, down upon the thigh; and every time the patient is moved, or raised even, as in sliding under a bed-pan, displacement to a greater or less extent is made at the seat of injury. Is it any wonder that imperfect union is the result?

At the present day, the weight and extension treatment or the immovable dressing is much more generally adopted than the time-honored long splint, which, as we have already seen, fails in great measure of securing such fixed apposition of the fragments as is a necessary prerequisite to proper repair. The weight and extension dressing, which answers so well in fractures of the shaft, when applied to those of the neck proves defective in so far as it permits of considerable movement at the seat of injury, does not control the outward displacement of the upper end of the lower fragment, and fails in the very essential requisite of any suitable fracture dressing, that it shall altogether prevent or reduce to a minimum movement of the joints immediately above and below the line of break. And, further, it does not and cannot keep the fragments in fixed relation to each other when movements of the trunk or limb are made; so that if changes of position of the body are effected, as they must and will be, more or less disturbance of the fragments must result.

The immovable dressing, to fully satisfy the requirements of the case, must embrace not only the thigh, but the pelvis, or at least the half of it, in order that the hip joint may be fixed, and the action of the hip muscles restrained as far as possible. And just here lies the difficulty in the application of such dressings,



and the imperfection of it as generally seen. From below the level of the great trochanter, the plaster of Paris bandage (and this is, of course, for many reasons, the best of the immovable dressings) can be put on; care being taken to properly cut it out and protect it on the inner side, so that no undue pressure shall be made upon the region of the genito-crural furrow, and that urine soiling shall not occur. But to carry it up to and over the iliac crest, and inward to the ischial tuberosity—in other words, to apply it over the whole gluteal region, and hold it there, requires an additional girdling of the upper part of the opposite half of the pelvis, or the carrying of the supporting dressing obliquely around the body, across the opposite lumbar region. Unless this is done, no matter how closely applied at first, in a few hours, or, at most, days, the dressing will be found to have sprung off, and to be no longer exerting due pressure upon the hip muscles; as the result of which, the motion of the joint will be little or not at all controlled, no more so than if the bandage had only been carried up over the trochanter major. Even if the immovable dressing has been properly applied and well maintained in position, there is always a chance that in consequence of wasting of the limb, sufficient loosening may take place to permit of some displacement of the fragments; to prevent which the weight and extension treatment may be very profitably combined with the fixed dressing.

Applied early, the immovable dressing saves the patient much suffering, and permits with safety, so far as the fracture is concerned, of such changes of position as will not only greatly add to comfort, but materially lessen the chances of the development of that hypostatic pneumonia, which is so often the direct cause of death.

The more experience I have had of this method of treating neck fractures, the more convinced I have become that by careful application of it we can secure better results with less trouble than in any other way; and I feel confident that in a large proportion of cases recovery will take place with a limb of good functional value.

Perhaps in the future it will be clearly shown that the rare occurrence of bony union in the past has been simply because the fragments of the broken femoral neck have not been kept steadily in apposition, but have, by the permitted motion of the hip joint and unrestrained muscular action upon the shaft, been allowed to so separate and play upon each other as that only an imperfect ligamentous repair has been possible.—*College and Clinical Record.*



## TETANUS.

The course of tetanus is remarkable from the exactness with which it follows, while at the same time it exaggerates and perverts, the normal reflexes of the nervous system. Other well-known diseases exhibit the same peculiarity in a different degree. Among these we may note the many forms of convulsion common to childhood, and the allied state of hysteria in the adult. In the former of these there is present, as a rule, a normal spinal cord, which is incited to impulsive and disorderly action by peripheral stimuli; in the latter, probably, along with such stimulation, an irritable cord, the cerebral will-control being in both cases ineffective. The pathology of tetanus in its turn, so far as that is known, exemplifies the further and extreme stages of the double affection. In the progressive inflammation travelling from the seat of injury upwards along the sensory nerves to their apparent origin in the spinal cord, we have suggested to us the plan and reason of its symptomatic action. The tendency of morbid nervous change to advance in the direction of the usual physiological impulses is also impressed in these lesion. Out of this progressive tendency arises the peculiar difficulty experienced in the treatment of tetanus. We have to combat a continual, not an intermittent stimulus. The intrinsic cause of mischief is almost from the first an inflammation of the torn or crushed nerve-terminations, which extends after its natural manner along the affected fibres, continually goaded by surface-irritation. Nor is evidence wanting which suggests that the central nerve-structures are apt to be involved, even at a very early period.

An important experiment by Brown-Sequard showed that irritation of an afferent nerve, if severe enough, can produce lesions in the spinal cord. An equal or less degree of irritation, due to superficial injury, especially if continuously active, might naturally be expected to lead to central congestion before the cord itself was reached by the progressive nerve-inflammation of tetanus. This may serve to explain those cases in which the disease is established within a few hours of the receipt of some peripheral shock. So far, the connection between tetanus and any septic agency cannot be regarded as a necessary one. Cases do undoubtedly follow the bites of wild animals, and are more common in hot and moist than in dry equable climates, and may therefore, seem to favor the theory of a bacterial origin. Such influence, however, as germs possess is evidently due rather to their general stimulant effect on inflammatory process, than to any special property.

The rational treatment of tetanus necessarily follows the indications of its pathology. Rest, accordingly, must form its

primary object—rest of the irritable nerve-centres in themselves, and in their peripheral relations. External warmth, silence, a darkened room, fluid nourishment administered in small quantities—in a word, the studied exclusion of every cause of nervous shock, however trifling, are part of the long established routine of treatment in such cases. Among drugs, chloral in full doses, and, better still, the subcutaneous use of morphia, have gained a merited preference. It will be found that, where injections of morphia have to be kept up for a considerable time, the plan of combining it with a minute proportion of sulphate of atropia is of assistance in counteracting the nauseous effect of the former drug. M. Verneuil, in a recent communication made before the Society de Chirurgie of Paris, further reminds us of the fact that these measures should be persevered in for a definite period, notwithstanding temporary remissions of the disease; since, if this precaution be neglected, relapses readily occur.

But, after all, medicine is rather an aid and a palliative than a principle in tetanus. So long as the original morbid change goes on unchecked, the action of the drugs, and of all merely general treatment, is met, and is liable to be thwarted, by the constant opposition of unchecked local stimulation. Until this is subsided, there can, of course, be but little hope of recovery. Relief of the central molecular changes must largely depend on timely control of the afferent stimuli. It should not be forgotten, moreover, that any surgical interference, in order to be effectual, must be early resorted to. The amputation of a crushed extremity, the section of nerves, or the removal of their torn endings by a clean cut, will avail nothing if resorted to some days—or even, it may be, hours—after the injury. By that time, the inflammatory action may be well established in the nerve-trunks. No time should, therefore, be lost in arresting the surface-irritation by such operative measures as may be indicated.

It may be well, before leaving this subject, to draw attention to the great value of moist heat alone as a sedative of the irritable nerve terminations. Besides the various forms of fomentation, medicated or not, we would especially mention the warm water-bath. A limb, if kept immersed for days in warm water, periodically changed, even without the presence of anti-septic or sedative agents, can hardly fail to lose much of this irritability; and the result, in absence of pain, in sleep thus gained, and in general comfort, must exercise the best influence on the centres in the spinal cord which are the foci of the tetanic convulsions. On the other hand, local sedative and disinfectant remedies, if required in any case, can, of course, be as easily administered in this way as in any other.—*British Medical Journal*.

## CHRONIC OTITIS MEDIA.

The appalling number of cases of chronic non-suppurative otitis media renders it altogether the most important field for study in otology.

Its treatment in a rational manner began, of course, with catheterization of the Eustachian tube.

For quite a number of years the catheter almost supplanted all other interference.

To supplement the action of the forcible introduction of pure air, medicated air and vapor and the injection of various sorts of fluids (irritant, astringent, alterative,) was resorted to.

Of late years more and more attention has been concentrated on naso-pharyngeal affections as the starting point and the continuing cause of this trouble.

And right here it would be important to know what effect, if any, the ordinary treatment of pharyngeal troubles has in starting up the affection under consideration.

We are all perfectly cognizant of the disastrous results following treatment of nasal catarrh, and every one must be perfectly aware of the care and study it requires to so treat the nasal and naso-pharyngeal space as to benefit the tube and middle ear, and how much more care is required not to do positive harm to them.

I have seen case after case of the most obstinate tubal and middle ear trouble (chronic) directly dependent upon nasal and naso-pharyngeal treatment.

I have myself over and over again aggravated matters instead of improving them, and that, too, with all the care I could exercise.

Now, if one whose whole attention is directed to the ear, and hence is in a condition to appreciate the slightest damage by or failure in the treatment, how much more is one liable to do harm who is taking little or no thought of these parts.

We all know that the nasal douche has been virtually discarded by aurists, even also the once apparently innocent post-nares syringe (with which I have often blocked an Eustachian tube). There are cases even in which inflation by any method, especially with the catheter, not only does no good, but positive harm. In fact a careful study of this trouble over a long series of years has convinced me that it is a most complicated and delicate chapter.

If it is so complicated and delicate, and I fancy no one will dispute the statement, it has always been a mystery to me why some of the best men in the profession turn over the treatment not only to unskillful hands, but even to the patients themselves.

I have met with a few cases in which the catheter had been



put by aurists into the hands of the patient, I need not say with what result.

Both patient and physician must be taught that the Eustachian catheter, like the urethral, is an instrument as potent for evil as good.

The profession is fast getting the idea that all ear cases should be catheterized.

A ludicrous illustration of this statement came under my observation while preparing this paper. A very reputable physician rather triumphantly informed me that he had been inflating his ears for quite a while with a catheter, but he was still deaf, and wanted me to see what the trouble was. It was ear wax!

It is certainly no unusual thing for the balloon to be put into the hands of patients and into the hands of parents.

These cases require a vast amount of time, care and patience, but those are not sufficient grounds for the slurring they receive.

The percentage of these cases, even when of long years' standing, that are not more or less amenable to treatment, is exceedingly small.

Unfortunately as yet our means of diagnosis are too imperfect to inform us as to the length of time treatment will be required, and as to how much benefit will accrue.

There is no special agreement even as to the means to be employed, nor as regards the manner of treatment, whether continuous or interrupted.

We constantly meet with the most discouraging expressions, both verbal and facial, from this class of patients. They are in the most discouraged state of mind, and extremely hopeless of treatment doing any good.

The majority, perhaps, when they hear that no very favorable prognosis can be made in regard to the relief of the annoying tinnitus are ready to abandon treatment.

I am fully persuaded that if all middle ear troubles could be ushered in with tinnitus it would be a most fortunate thing for this class of patients, as we would then see them early.

Of course *it is not the tinnitus that is so discouraging, but the cerebral state due to the ear trouble.*

Nothing is more common than to hear ear patients after inflation remark: "Now my head feels better." If my experience has taught me anything it is that the mental depression can be relieved so that the tinnitus is no longer disturbing, even when no improvement has taken place in the hearing. The great difficulty in these cases is in tiding patients over the first few weeks or months.



It is a great mistake to think that because the Eustachian tubes are closed only catheterization will open them.

Over and over again I have found some applications of vaseline and boric acid, or what is better (since we have such impure acid preparations of vaseline) the yellow oxide of mercury and vaseline (10 grs. to the oz.), used through the nostrils, open tubes where catheterizations had little or no effect.

In this connection I would say that salves, for me, have almost if not quite superseded all other applications for nasal and naso-pharyngeal troubles.

My clinical studies will, I think, justify the following conclusions:

1. Only experience of sufficient length of time (often lasting over months) in each case can determine whether treatment shall be continuous (daily) or interrupted, *i. e.*, perhaps daily for a few weeks, followed by an interruption of some weeks or months.

2. Only experience in each case can inform us whether treatment is to be directed entirely to the middle ear or entirely to the naso-pharynx, or combined against both.

3. Only experience in each case can inform us whether injections into the cervical tympani are called for.

Under this head I would say that strict medication, either of the middle ear or naso-pharynx as routine treatment is unwise till simple inflation has failed.

4. Mechanical dilatation of the tubes is rarely necessary or advisable.

I would remark here that only in extremely dry states of the tube is dilatation followed by much success.

5. Hearing tests are not reliable, and hence patients with great deafness, great loss of bone conduction, etc., should not be sent away till the "test by trial" has been thoroughly gone through with.

6. Simple inflation failing, the greatest attention should be given to the naso-pharynx, even though it is in an apparently fair condition.

7. Syringing, douching and swabbing the naso-pharynx should be abandoned. — *W. W. Seely, M. D., in Lancet and Clinic.*

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## SURGICAL TREATMENT OF INFANTS.

First of all, must the children's surgeon acquaint himself with the anatomy of the child. This is rarely done, as the ordinary adult dissections during a college course give little idea of

the size and position of the individual elements as seen in the infant. In consequence of ignorance upon this practical point, many grievous failures have occurred. After unusually large opportunities for the study of both normal and abnormal tissues in the diminutive frame, I am still frequently surprised to note the exceeding smallness of different organs and canals.

Another essential element in the surgeon is tact in the management of the little ones, especially when dealing with those between the ages of two and ten. In hospital cases but little history is attainable, and much depends upon quick perception. Naturally fearful of pain, the patient's mind must be diverted and engaged, or great difficulties in diagnosis will often occur from the fright and struggling. The operator not in sympathy with children can never secure their confidence. Much will often be gained by quiet observation. It is not a month since my opinion, which at the first few moments of the consultation had been favorable to tracheotomy, was changed by five minutes close watching, and the result proved the correctness of the procedure. To the person, however, who will carefully study individuality as well as disease, no departure of medicine offers so pleasant a return for his labors. My personal experience with children has perhaps made me more hopeful in regard to the power of such individuals to endure pain, shock and disease, than would be indicated by the expressions of other authors; but to me there is no domain of surgery so attractive and gratifying as the treatment of children below the age of puberty. Their natural condition is that of hopefulness, and as soon as the depressing influence of the shock, pain or fear is removed, the normal resiliency of mind and body asserts itself with such rapidity that the results are often surprising.

Again, a child has only inherited taints of constitution to contend against, his viscera are ordinarily in a healthy condition, an adult has not only hereditary, but all the acquired vices occasioned by misuse of any organ or set of organs, a circumstance which often turns the scale in the struggle between life and death. Take, for example, the single instance of the outraging of tissues by either the moderate or the excessive use of alcohol, and every surgeon will testify that even slight wounds may, in such an individual, quickly develop a fatal attack of mania-a-potu.

Tetanus is more frequent in infants than in adults, notwithstanding the tendency of the former to nerve excitability.

In regard to anæsthetics, my experience is that great benefit is obtained by the use of ether when pain can thereby be prevented. In the first weeks of existence, I admit that a feeble vitality would contra-indicate its use, although I have successfully administered it to a three-days-old infant. After the first or sec-

ond month, I see no reason why we should needlessly inflict pain upon an infant simply because we can control it by brute force. In the examination of fractures, great suffering is often inflicted by careless and frequent manipulation, and unless the diagnosis is easy and positive, unconsciousness should be produced. No case of bone injury should ever be passed by undiagnosed, when ether will solve the question.

In the opening of abscesses, the "primary quieting influence" of ether is so readily obtained that it should be brought into use whenever practicable, as keenness of pain can thereby be avoided.

All preparations should be made out of sight and hearing of the patient and instruments need ever be seen by him, except when a strong impression is intended to be made upon the mind of a masturbating boy, requiring circumcision.

One word in regard to the method of anæsthetization. It is but natural that a child should be distrustful of any attempt to deprive him of consciousness, a fear which is greatly increased by the injudicious and greatly to be condemned habit of many parents, who systematically threaten their offspring with the expression, "the doctor will come and cut your head off." A few kind words will often quiet the agitation, and simple directions as to the method of breathing, will save many minutes of struggling resistance. With very young children, the first smell of ether may be masked by permitting them to see cologne poured upon the towel after which ether may be quietly added and they will feel that it is a perfume that they are breathing. This device has frequently served me a good purpose. I always allow a good admixture of fresh air for the first moment, but when the child actually begins to cry, then quick action answers best. The towel should now be well saturated and held firmly over nose and mouth until two or three strong screams and inhalations will yield a full primary impression which can be gradually followed up to complete anæsthesia with safety.

Should any symptom of ether narcosis occur, it is so easy to depress the head of a child or to perform artificial respiration by acting upon the ribs, that serious accidents are infrequent. Subsequent vomiting is very common but is not persistent and is easily quieted by a small hypodermic of morphia, a procedure which ordinarily brings quiet sleep to the patient. If the child is feeble, I always allow milk up to within two or three hours of the operation, and then administer wine or whisky in water immediately before giving the anæsthetic. Milk with lime water and whisky is usually retained within ten minutes after the first vomiting on rousing. In tedious excisions, not only should preliminary precautions be taken to secure against prostration by



shock, but hot water bags should be ready for use, which with hypodermics of brandy, may succeed in tiding over a temporary depression which would otherwise end in death. When the loss of blood has been great, especially in acute surgery, important assistance may be gained by transfusion, either of blood or of a warm saline solution.

Under the head of arrest of hemorrhage, I would strongly advocate the use of animal ligatures, since the pain often incident upon the removal of threads, greatly disturbs the needed quietude of wound and mind.

Thorough asepsis and antiseptis are especially valuable, since we not only secure the admirable results that are attainable by their use, but are also enabled to disturb the child with far less frequency. I am now treating a girl with a railroad crush of the leg which would thoroughly have justified amputation, yet which under corrosive sublimate dressings has not been touched but six times in as many weeks even though extensive sloughing has occurred. Save, upon one occasion, at the height of the process of tissue death, the applications have been taken away perfectly sweet; and the child has the promise of a reasonably good limb. In my *ante-septic* days, I certainly was never able to carry a patient through such a process and keep the temperature as has been done in this case, below  $99\frac{1}{2}$  degrees all the time, and usually but slightly above  $96$  degrees. With frequent dressings, the irritation of the child is but slight, and if pain is also absent, contentment is the rule, under proper nursing.

I cannot so strongly emphasize the importance of this latter condition. A kind, quiet, gentle nurse, is one of the most valuable assistants in the real progress of the case, especially during the first week following operation. Such care cannot be delegated to untrained and careless people, hence it is absolutely necessary that children should be in separate hospitals, or in separate wards, under the best of care takers. Even in private practice, the mother is rarely the best nurse for a child past two or three years of age, and a skilled attendant answers best. In hospital practice, I have often been surprised to see how contented and patient the majority of children of even three years of age will become, if the mother maintains a judicious absence and the nurse is efficient and kind.

Another point which I wish most emphatically to emphasize to-night is, the fact that congenial defects are most inexcusably and persistently neglected by even good practitioners. Either under the mistaken opinion that nothing can be done, or that a later period will be early enough. The consequence is that many unfortunates become helpless and hopeless cripples by their physician's advice, since passing out of his sight and mind, the



neglect engendered by his direction, "wait," is fostered by parents, ever ready to postpone a dreaded day.—*St. Louis Med. and Surg. Journal*.

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### ALBUMINURIA—ITS CAUSES AND VARIETIES.

"Senator," in the *Berliner Medical Wochenschrift*, No. 16, April 20, 1885, enumerates the following conditions liable to determine the presence of albumen in appreciable amount in the urine:

Disturbances of the renal circulation. High pressure, if the urine be concentrated, should produce albumen. This condition is actually found to obtain by muscular action, on account of perspiration and loss of fluid by the lungs, and, though not so accurately, by elevation of temperature.

Passive hyperemia acts in itself similarly to increased arterial tension, but the distended veins in the medulla of the kidneys press together the urinary tubes, leading to obstruction of the passage of urine and œdema of the kidneys. The consequence is:

1. That albumen transudes from the interstitial capillaries into the urinary tubes.

2. That urine exerting pressure upon the glomeruli produces a diminution of pressure from the glomeruli, and leads to a relative increase of excretion of albumen. To this cause of albuminuria is allied that caused by blocking of the urinary tract, manifested when the impediment is removed, or when the obstruction is not complete.

3. The condition of the filtering membrane, as in inflammation, fatty degeneration, and amyloid change. Not only does albuminuria result from an increased permeability, but the degenerated membranes and epithelium themselves appear in the urine as albumens, and this may explain the fact that in the urine albumens may have a different relation to each other from what exists in the blood. The substance of the epithelium appears to contain a body intimately allied with globulin.

4. The composition of the blood may cause the appearance of albumen, e. g., from an excess of nutriment, from increased dissolution of albumen, or from excessive secretion of water elsewhere, etc. It is held by Rosenbach, that the composition of the blood is constantly regulated by the action of the kidneys, and that inassimilable albumen is excreted by the kidneys. Albuminuria not caused by inflammation, this author designates as "regulatory." His idea, though important, is not free from objections.

Finally, as Stokvis and Lehman have pointed out, the excretion of albumen can act injuriously upon the kidneys.

5. Mention has already been made of the influence of temperature in connection with changes of pressure.

The author further remarks that the forms of albuminuria may be clinically divided into two classes, pathological and physiological, although no exact line of demarcation distinguishes them. Among physiological albuminurias may be mentioned that of the new-born, which is probably due to the suddenly increased pressure in the glomeruli, taken in connection with the probably increased destruction of the blood corpuscles.

Albuminuria can exist in a healthy man for years without any signs of ill-health, and then cease.

Fuebringer, too, has found this condition in children, in whom chronic nephritis is very rare.

The author, in this connection, alludes to the albuminuria due to mental perturbation, and to that caused by cold baths.

Pathological albuminuria includes the following:

1. That present in non-febrile diseases, in which the composition of the blood is specially concerned, and in which the kidneys do not participate to any extent; in anemia, leukemia, and pseudo-leukemia; in scurvy, in icterus and in certain cases of diabetes. Nothing is found in the urine indicative of renal disease.

2. Albuminuria in non-febrile nervous diseases, in epileptic seizures, delirium tremens, cerebral apoplexy, neurasthenia, migraine, Basedow's disease, etc., and allowing for other existing causes, numerous cases exist where the albuminuria is traceable only to the nervous condition.

3. Febrile albuminuria. In this condition there is a combination of favoring causes, such as high temperature, febrile changes in the circulation and in the composition of the blood, with consequent disturbance of the nutrition of the kidneys, and, lastly, concentration of urine.

4. Albuminuria of passive hyperemia.

5. That due to blocking of the urine.

6. The albuminuria of pregnancy due to various causes, disturbance of the lesser circulation, passive hyperemia due to abdominal pressure on the vessels, and constriction of the ureters.

7. That due to diffuse inflammation and degeneration of the kidneys (acute nephritis, subacute and chronic and amyloid degeneration).

9. That depending on circumscribed affections of the kidneys, such as infarcts, abscesses and tumors.

In conclusion, the author insists on the necessity of constantly remembering that the treatment of each individual case of albuminuria varies with the exciting cause.—*Medical News*.

## PERITONITIS OF LOWER ABDOMEN—PERITYPHLITIS.

The general experience of pathological authorities shows that in a very considerable portion of fatal cases of inflammatory lesions in the ilio-cæcal region the *processus vermiformis* is in some way or other the source of the inflammation. In the minority there is inflammation of the cellular tissue lying chiefly behind the cæcum and ascending colon; and in such cases the peritoneum may escape implication, the abscess opening directly into the cæcum. And as in the case of the uterine organs the names perimetritis and parametritis have been employed; the former, however, embracing by far the greater number of cases and being accordingly much the more familiar term in works on the subject. There is, moreover, a certain number of cases in which, though the inflammatory processes extend to the neighborhood of the cæcum, they do not originate there; as where a pelvic abscess (parametritis) burrows upward along the sheath of the psoas and iliacus muscles, or where a spinal or perinephric abscess burrows downward along the same sheath, and may end in forming a communication with the bowel, or by opening in the groin. In these cases the peritoneum usually remains exempt.

Now, in the cases which recover (and these are the large majority) it is often not possible to make an exact diagnosis of the seat of the primary lesion, and therefore it is vain to attempt to classify them as above; but in many or most of them the local peritonitis, extending from the right iliac fossa upward and inward, is the most prominent fact, and the name perityphlitis is applied without a too curious inquiry into the unknown origin of the lesion. The evidences of the inflammation are the pain, superficial or deep; tenderness on pressure, increased resistance, swelling, and dullness on percussion in the right iliac fossa; fever, often with repeated shiverings, and usually of a remittent type, which may go on, in protracted cases, into a kind of hectic; the bowels being more often than not constipated, but occasionally with intervals of diarrhœa. Vomiting is by no means a constant feature of such cases, but is sometime pretty obstinate. Indeed, I have known the vomiting and constipation together such as to raise serious questions as to the existence of a mechanical obstruction or invagination of the bowel; but usually it is not so. In well-marked cases, the dense semi-solid feeling of impaction extends quite down to the pelvis; in others, towards the middle line, and sometimes even above the umbilicus; and, in the female sex, it may be only after careful examination of the pelvic organs that such cases can be distinguished from peritonitis of pelvic



origin. Occasionally, and especially when it is expedient to make such examination, owing to the patient being unmarried, or to the rapid recovery, it remains a doubtful question to the last. I have seen several such cases in female children who all made good recoveries; and although these cases passed for perityphlitis, I am by no means sure of the pathology of them even now.

The most important clinical fact, however, to keep in view in dealing with such cases, is that a large proportion of them do, in fact, recover more or less completely, and after a longer or shorter period of careful management. This favorable prognosis is not commonly set forth, at all events so as to have impressed my own mind, in the various monographs on typhlitis and perityphlitis; perhaps owing to the fatal cases, and those submitted to *post-mortem* examination, being chiefly accumulated in medical literature, and thus becoming unduly prominent. In one very admirable memoir, however, I find the view now presented fully more strongly asserted than I should have been disposed to put it, even apart from the evidence in the cases above noticed. "I believe," writes the late Dr. Hilton Fagge, "that even when acute peritonitis is set up by ulceration of the cæcal appendix, the disease, if properly treated, is infinitely less dangerous than is supposed. I have never myself seen a case of this kind terminate in death, when its nature was correctly diagnosed, and when no purgatives nor enemata were allowed to be given. Nor of late years have any fatal cases occurred in the hospital (Guy's), except a few cases in which death occurred very shortly after admission. I have, therefore, been accustomed to give a favorable, though guarded, prognosis in cases of typhlitis, even when symptoms of diffused peritonitis are present. It may, of course, be said that the very fact that one can make an exact diagnosis proves that the disease is not running on to a fatal termination within the first few hours, and that the signs of the general inflammation do not preponderate very greatly over those of the local mischief; and I am ready to admit that there may be cases of sloughing of the appendix which are necessarily fatal. But, as I have shown, the differences in cases of typhlitis appear to be differences of degree, and not all of kind; and I believe I am justified in saying that when this disease is skilfully treated it scarcely ever terminates otherwise than in the recovery of the patient."

Dr. Fagge further argues that there is no good reason to suppose (as has been supposed) that such cases, when they end in recovery, "differ essentially from cases of perforation of the appendix," which he regards as "really always the starting-point of the inflammation." He alludes to three cases in which it



was pathologically determined that perforation was the cause of an attack which had virtually ended in recovery, when either a new attack of perityphlitis, or an intercurrent disease, attacked and carried off the patient. The most important of these cases is the following: "A patient suffering from chronic pleurisy was attacked with pain in the right iliac fossa, and the other symptoms which I have just mentioned; a firm tumor, dull on percussion, could be felt in the right iliac fossa. Under careful management, the abdominal disease subsided, but pneumothorax occurred, and of this he died a few days afterward. The cæcum was closely adherent, a small collection of purulent matter surrounded the vermiform appendix. This was perforated at its extremity, and outside it lay a small mass of hardened fæces."

I have already conceded that it is often impossible, clinically (in cases which end in recovery), to be sure of the exact seat and nature of the original lesion; and to this extent I am disposed to think that the weighty and striking sentences above quoted, from a great master of clinical and pathological investigation recently removed from us, may require some qualification. But the words of a man like Hilton Fagge must be taken as implying not only strong conviction, but conviction founded on an amount of closely observed fact, which is perhaps not fully brought out in the details of the memoir itself. There are many circumstances tending to the belief that peritonitis even from perforation of the small intestine is not so absolutely desperate a case as it has been frequently represented; and we have already seen that peritonitis of considerable severity and diffusion, arising from pelvic causes, admits of resolution, in many instances, with a completeness and rapidity that it is not easy, pathologically, to explain. The vermiform appendix is placed so as to offer the most favorable conditions possible for the isolation and limitation of the results of an ulcerated lesion, or even of a perforation; but it is not necessary to suppose that in most, or all, of these cases actual perforation occurs, if we only accept the idea that an ulcerative or other lesion tending to perforation is usually forestalled, as it were, by reparative processes which may often tend to prevent the threatened fatal rupture. In such processes, adhesive peritonitis, I believe, plays a principle part, and it is only a question of degree whether the extension and the character of the peritonitis are such as accurately to fulfill this, its conservative work in the organism, or such as to become more or less of a disease and a danger *per se*. At all events, there seems no escape from the conclusion that in some cases, at least (such as the one above quoted), even perforation of the vermiform appendix may be followed, or accompanied, by what nearly amounts

to a complete recovery, through adhesion of it to the surrounding parts.

Dr. Fagge further points out that "typhlitis often recurs again and again at intervals of a few weeks. It is also exceedingly apt to relapse during convalescence if the patient is allowed to commit any indiscretion." This statement I can fully confirm, and the importance of it, from a practical point of view, in connection with the preceding observations, need not be more particularly pointed out. The treatment of all such cases should be conducted on the same principles (*mutatis mutandis*) as in peritonitis of pelvic origin. Rest of the parts, absolute, if possible, is the main indication of treatment, and this, in the case of the cæcum or vermiform appendix, implies, of course, abstinence from the use of purgatives, and not unfrequently, also, the administration of opium, and the limitation of the diet. Enemata, if employed at all, should be only such as to empty the rectum; but, on the principle that a lower bowel loaded with fæces is more open to strain than one cleared out by warm water in moderate quantity, I am not sure that I am prepared to accept without some qualification Dr. Fagge's conclusion that enemata, as well as purgatives, are to be entirely proscribed as a first condition of safety. It is perhaps necessary, however, to protest against Eichhorst's special recommendation of large cold water enemata three or four times a day in what may chance to be regarded as typhlitis stercoralis. I cannot say that I have had such experience as would induce me to pronounce this an entirely distinct form of disease; and if, on the other hand, the constipation, which often attends a case of inflammatory swelling in the iliac fossa, is not to be taken as the cause, but as the result, of the inflammation, usually, if not always, associated with ulceration of the vermiform appendix, a treatment founded on mere emptying the lower bowel, mechanically or otherwise, cannot be expected to be successful. A liquid diet, at first exclusively employed, and afterward only a very gradual introduction of the most completely digestible solid foods, will be rightly held to be imperative, owing to the same very obvious and paramount necessity of securing rest, as far as possible, to the whole intestinal tract, and especially to the cæcum. In cases where vomiting is obstinate and long-continued, I should not be restrained from clearing the rectum of its contents so far as to allow of nourishment and stimulants being given per anum: and morphia might in such case be used in considerable doses hypodermically. The patient should be rigidly kept in bed, and absolutely in the recumbent posture, until the tenderness and swelling are nearly if not quite gone; and, holding in view the risk of relapse, it is hardly possible to insist too much upon great care in this respect.

The only local treatment I am disposed to recommend is the use of fomentations (medicated or not); poultices (if not too heavy): sometimes, if there is much distension, or if the fever is very high, the local application of cold for short periods by iced cloths; and, in more chronic cases the painting of iodine tincture, or liniment.—*Med. Times and Gazette.*

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## ULCERATION OF THE BOWELS IN YOUNG INFANTS.

It cannot, I think, be questioned that a speedier and more accurate information as regards the effect of remedies may often be gained from the study of chronic than of acute disease, inasmuch as the same symptoms are apt to recur again and again, and the same remedies can be put to oft-repeated tests. The following case, which I have ventured to report, has given me an amount of information it might otherwise have taken years to obtain, and possibly it may prove of service to others. According to the mother's statement the child in question had been given up by more than one physician, and I must say myself it was one of the worst cases I have ever seen recover. The little one was two years and eight months old, a perfect skeleton and quite unable to sit up. She had a sallow waxy appearance, without a particle of color about her face except a slight hectic flush on her cheeks. Was sick whenever she took food, which consisted entirely of milk and lime-water. Bowels moved about every four hours and the smell was perfectly unbearable. The stools consisted almost entirely of slime and pus, streaked with blood, and adhering to the bottom of the chamber vessel even when it was held upside down. The stomach was slightly distended and tender. The previous history was as follows: She was always rather sick from birth, but was worse after she was one year old. Had an attack of diarrhœa at eight months and urine was discolored (so the nurse says) with blood. She has always been troubled with diarrhœa on and off since. The stools were at first very large in quantity and semi-solid but not slimy. When the diarrhœa was at its worst, the actions occurred about every two hours. The stomach was always more or less tender and distended. At twelve months old she had pains in the joints, and one knee had to be put up in a splint; both legs were much swollen. The father had had syphilis before his marriage, but was said to be perfectly well when this took place. The child was nursed for about four months, but occasionally had a bottle of Swiss milk. The indications for treat-



ment appeared to me to give a light and easily digestible food, moreover one which after digestion would leave as little waste material as possible, to soothe the irritation of the bowels, and to improve the condition of the blood. I ordered two tablespoonfuls of whey, and one tablespoonful of cream to be taken at each feeding, and in the course of twenty-four hours I found she managed to dispose of  $\frac{1}{2}$  a pint of barley-water,  $\frac{1}{2}$  a pint of whey,  $\frac{1}{4}$  of a pint of cream, together with, later on,  $1\frac{1}{2}$  ounces of milk. She also took in twenty-four hours the white of four eggs beaten up in water, four teaspoonfuls of Brand's liquid essence of beef, and two ounces of finely-minced raw meat. I ordered the body to be thoroughly oiled night and morning, the loins and stomach to be kept warm with a flannel bandage, and the feet to be well wrapped up. In order to alter the character and frequency of the secretions, I gave three times daily a mixture consisting of the following: one minim solution of potash; eight minims castor oil;  $\frac{3}{4}$  of a minim tincture opium; twenty minims syrup ginger, and  $\frac{1}{2}$  a drachm mucilage. Then when the pus and slime began to pass away and the bowels appeared simply relaxed, I gave two grains bicarbonate soda; three grains subcarbonate bismuth;  $\frac{1}{2}$  a minim tincture opium; five minims tincture catechu; two minims tincture rhubarb; five minims compound tincture cardamoms with a little syrup and mucilage every four hours. Next, in order to improve the condition of the blood, as soon as the secretions began to improve, I ordered ten minims of the concentrated syrup of the lactophosphate of lime and iron to be given in water three times daily. The child was ordered from the start to get plenty of fresh air provided it was dry, and the rooms in which the child lived and slept were requested to be kept quite dry, and at the same time thoroughly clean and ventilated. In the course of about  $1\frac{1}{2}$  years the child under this treatment made a good recovery, and was able to run about by herself and eat the same as any other child. The vomiting ceased almost entirely from the time that the milk was given up. Whenever the secretions became purulent and slimy the castor-oil and laudanum mixture was resorted to, and the carminative and astringent one when the bowels were simply a little relaxed. The castor-oil and laudanum was successful in altering the character of the secretions, not simply once or twice, but on several occasions, and I have applied it since in other cases with uniform success. As regards the lactophosphates, I cannot speak too highly of them in aiding the subsequent recovery. As Dr. Dusart states, they act as general excitants of all the nutritive functions, insure digestion, bring back or increase the appetite, and generally improve the vital energies.—*Practitioner*.



## NASAL ASTHMA—ITS CAUSES AND TREATMENT.

Dr. G. Hunter Mackenzie thus writes in the *Brit. Med. Jour.*, May 16, 1885: The casual relationship between nasal disease and asthma was first pointed out by Voltolini in 1872 (referred to by Morell Mackenzie, *Manual of the Diseases of the Throat and Nose*, Vol. ii., p. 360), and since that time numerous cases have been recorded which have established the accuracy of this observation. In all these instances, with one exception recorded by myself (*Edinburgh Medical Journal*, February, 1883), polypi, or marked swellings of the nasal mucous membrane, have been the varieties of disease present. This has given rise to the theory held by some, that the asthma is owing to mechanical obstruction to the passage of air; and additional confirmation of this view is supposed to be afforded by the disease disappearing on the removal of the obstructing mass.

Against this theory two arguments can be advanced: the frequency of polypus or tumefaction of the nasal mucous membrane without asthma, and the presence of nasal asthma without the recurrence of either. The first is a matter of every-day experience, and the second has received illustration by the case above referred to, in which violent paroxysms of asthma were associated with a condition of chronic (atrophic) inflammation of the nasal mucous membrane, and ceased on the application of nasal remedies; and by the following case that has recently come under my notice:

A boy, aged thirteen, was brought to me on January 23d, 1885, on account of a copious watery discharge from the nose, and asthma. He had suffered from these for about ten years, with slight periods of remission. The asthmatic attacks were often very severe, and generally occurred about 4 or 5 a. m. The condition of his nose necessitated the use of from twenty to thirty handkerchiefs daily. Anterior and posterior rhinoscopy showed chronic catarrh of the nasal mucous membrane, with a slight amount of muco-purulent secretion. There was no polypus or thickening of the membrane. Though not robust, he presented no indications of disease elsewhere. (This patient has, apparently, quite recovered under the after-mentioned treatment.)

What is the explanation of such cases? I believe the asthma to be owing, not to any mechanical obstruction of the nasal passages, but to a condition of abnormal irritability of the nasal mucous membrane, due to or aggravated by chronic inflammation. Polypi may, or may not co-exist; when present, they doubtless assist in maintaining the augmented irritability of the mucous lining. The high degree of normal sensitiveness of the mucous

membrane of the nose is well known; and when this membrane has been the subject of long-continued inflammation, its irritability appears to become highly augmented, and more easily excited. Reflex acts are then readily induced, of which sneezing, cough, and asthma are the principal indications.

The peripheral irritation may be caused by dust or pollen, and hence the attacks are usually worse in midsummer and autumn; by cold, therefore, their frequency in the early morning hours; or by the irritation of a polypus. Dr. John Mackenzie has recently stated (*Transactions of the Medical and Chirurgical Faculty of Maryland*, 1884) that asthmatic attacks in cases of nasal polypus only occur when the growth is, by force of gravity, brought against the posterior part of the nostril, corresponding with the most excitable spot in the sensitive area. On the other hand, Hack, quoted by Morell Mackenzie (*Manual of Diseases of the Throat and Nose*, Vol. ii., p. 361), considers that reflex phenomena may be produced by irritation of any part of the lining membrane of the nose.

Associated with the asthma are usually excessive sneezing and profuse discharge of mucus from the nose, occasionally cough. There is more or less impairment of the general health, with languor and depression of spirits.

The treatment of these cases must obviously, in the first place, be directed to the removal of the exciting cause. The patient ought to be directed to reside in an atmosphere as free as possible from dust and other atmospheric impurities. Above all, active medication should be directed to the nose; and, after a fair trial of various remedies, I have found none so efficacious as belladonna, applied in the form of buginaria (nasal bougies). From one-twelfth to one-sixth of a grain of the extract ought to be incorporated in each bougie, one of these being introduced into each nostril night and morning, and allowed to thoroughly dissolve there. I have found their employment most beneficial, alike in regard to the sneezing, the secretion and the asthma. Their use is usually followed by a burning sensation in the nose, but this is never severe, and soon disappears. I have also experimented with the sulphate of atropia in the same way, but have found it less efficacious, and probably more irritating than the extract. Previously to the introduction of the bougie, the nasal mucous membrane may be cleaned by the anterior nasal spray. The use of the bougies may be gradually made less frequent, according to the amount of success achieved.

The cases which I have hitherto watched, have rather belonged to the atrophic than the hypertrophic form of rhinitis, but where vascular engorgement is present, it seems probable that

the use of cocaine bougies would be beneficial. According to Bosworth (*Internationales Centralblatt für Laryngologie und Rhinologie*, No. 8), this drug has a remarkable effect in diminishing the vascularity of the lining membrane of the nose. In acute nasal catarrh, its local application has only a temporary effect.

The treatment may be combined with the administration of tonics, and such other general remedies as may be deemed suitable by the physician. By themselves, these are, however, singularly inefficacious. I venture, therefore, to commend to the profession the use of nasal bougies, containing belladonna, as an effectual method of treating the troublesome and obstinate complaints dependent upon chronic nasal catarrh and irritability, of which asthma is alike the most important and most intractable.

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#### WHITE OF EGG IN OBSTINATE DIARRHŒA.

From the *Allg. Med. Cent.-Zeit.*, we learn that Celli has recently called attention to the curative properties of the albumen of hen's eggs in severe diarrhœal affections. In a discussion before a medical society at Rome, he advocated its use, and related two cases of chronic enteritis and diarrhœa, which having resisted all treatment, speedily made complete recoveries under the use of egg-albumen. The same diet is strongly recommended in the diarrhœa accompanying febrile cachexia, and in that of phthisis. In two cases of diarrhœa dependent upon tertiary syphilis, it was found of no avail. On *post mortem* examination diffuse amyloid degeneration of the arterioles of the villi was found in these cases. The mode of administration is as follows: The white of eight or ten eggs are beaten up and made into an emulsion with a pint of water. This is to be taken in divided quantities during the day. More may be given if desired. The insipid taste can be improved with lemon, anise or sugar. In case of colic, a few drops of tincture of opium may be added.

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#### ICE TO THE SPINE IN OBSTINATE VOMITING.

Dr. Wm. L. Davis, in the *Mississippi Valley Med. Mo.*, says: I was called to a patient, æt. forty-seven, the mother of nine children, suffering from a severe typhoid fever with intractable vomiting, which had persisted for several days. All of the ordinary means failed to control the condition of the stomach, and even pellets of ice were instantly rejected. High temperature characterized the fever, and every effort was made for its reduction, believing that it had much to do with the production

of the nausea and vomiting, but the latter prevented the medication indicated for this purpose.

Menstruation had been normal for some time, except the epoch just preceding the attack of fever, which, although the flow made its appearance, was but limited in quantity. From the age of the parent and the number of children she had borne, I was inclined to the belief that the climacteric was a factor in the gastric derangement. Thinking, therefore, that the vomiting might depend upon reflex disturbance of uterine origin, or ill-defined spinal derangement, I applied ice in considerable quantity to the lowest part of the spine. The vomiting ceased instantly, and a profuse perspiration followed. The use of the ice was persisted in only as the indications appeared to demand it. Taking the hint from this, however, cool sponging was instituted with marked benefit, so that the use of the extreme cold to the spine was only of occasional necessity. With the exception of anodyne injections to produce rest at night, little other treatment was ordered. The subsequent progress of the case was satisfactory, and the ultimate recovery complete in about the average time.

The history of the case since her getting up has not confirmed my conclusions in regard to the menopause.

### CLASS-ROOM NOTES.

In wounds upon the face, Prof. Gross covered the sutures with a solution of iodoform ten parts, collodion ninety parts.

Prof. Gross says: When we find a heavily coated, furred tongue, give 3 grs. calomel, followed by 2 dr. each, of Rochelle and Epsom salts.

In gastralgia, Prof. Bartholow has often obtained good results from—

R. Atropinæ sulph.,	1 gr.	
Zinci sulph.,	$\frac{1}{2}$ dr.	
Aquæ destil.,	1 oz.	M.

SIG.—Three to five drops twice or thrice daily.

The lead water and laudanum solution of Prof. Gross is as follows:

R. Plumbi acetatis,	2 scruples.	
Tinct. opii,	$\frac{1}{2}$ oz.	
Aquæ,	1 oz.	M.

SIG.—Lotion.



A young man who had for several years practiced masturbation, applied at the clinic for relief, as he was suffering from a morbid sensibility of the urethra, with constant, sticky discharge from that canal. He was given, by Prof. Gross—

R. Potass. bromid,	1 dr.	
Sodii bicarb.,	15 gr.	
Inf. digitalis,	$\frac{1}{2}$ oz.	
Atropinæ sulph.,	1-60 gr.	M.
Sig.—At bedtime.		

In case of cerebral hyperæmia consequent upon a blow, Prof. DaCosta prescribed the following active purgative:—

R. Ext. colocynth,	1 gr.	
Capsici,	$\frac{1}{4}$ gr.	
Ext. gentianæ,	2 gr.	M.
Sig.—Ter die, in pill.		
At night, sodium bromide, 25 gr.		

A man, 63 years old, suffering from mitral stenosis with hypertrophy, and in whom atheromatous degeneration of the blood vessels was present, was given, by Prof. DaCosta, fluid ext. of convallaria, 8 drops ter die, to make heart beat more regularly: Fowler's solution for the atheroma.

A boy, 4 years old, had recurring spasms. Two years previously he fell, striking on his temple, causing instant paralysis on opposite side. Was given by Prof. DaCosta—

R. Potass. iodidi	3 gr.	
Potass. bromid.,	5 gr.	
Elix. aurantii,	ad	1 dr. M.
Sig.—Ter die.		

To prepare his ligatures for use, Prof. Gross uses McCuen's method: Take 1 oz. of chromic acid (crystals) to 5 oz. of water. Of this solution take 1 oz. and to it add 5 oz. of glycerin. In this latter steep the animal ligatures for ten days, then remove and thoroughly dry them. Now, for preservation, keep them in a  $\frac{5}{100}$  solution of carbolic acid.

For a case of infantile paralysis of two or three week's duration, in a girl æt. 4, in which the paralysis involved the right upper extremity and the left lower extremity, Prof. Bartholow brought about a good result by massage, also the administration of lactophosphate of calcium with ol. morrhue. Strychnia was injected into the muscles.

Dr. Sajous, at the hospital, treats post-nasal catarrh as follows: First a purgative, as sulphate of magnesia, 2 scruple, then use as a "snuff" ter die—

R.	Bismuth subcarb.,			
	Pulv. acaciæ,	aa	$\frac{1}{2}$ dr.	
	Zinci sulph.,		10 gr.	
	Morph. sulph.,		2 gr.	M.

At the hospital, Dr. L. Webster Fox prescribed for a case of acute conjunctivitis:—

R.	Acid borici,		12 gr.	
	Aquæ camphoræ,			
	Aquæ destil.,	aa	2 oz.	M.
Sig.	—Eye lotion.			

Should this fail, use something stronger, as zinc chloride, 2 gr. to 1 oz. In the third stage, where we are confronted with granular lids, use the caustic copper, in sticks.

Dr. Fox also spoke of jequirity in troublesome granular lids, to wit: Bruise 1 oz. of the beans to a pint of water. Take a little of this solution and apply to the eye, and in a week we obtain a smooth surface.

To diminish the sensibility of the mucous membrane of nose, Dr. Sajous uses—

R.	Acid. tannic,		40 gr.	
	Glycerini,		1 oz.	M.
Sig.	—Apply with a cotton-wrapped probe.			

A solution of zinc chloride, 2 gr. to 1 oz., is also useful, or 5 gr. to 1 oz. of the zinc sulpho-carbolate.

To get rid of effusion when the above is of no avail, let the patient sit covered with a sheet, and place a lamp within to steam him; or use—

R.	Bismuth. subcarb.,			
	Pulv. talc.,	aa	1 dr.	
	Alumnts,		$\frac{1}{2}$ dr.	
	Morph. sulph.,		1 gr.	
	Pulv. acaciæ,		1 dr.	M.

Sig.—To be used as snuff, several times a day.

The following treatment, by Dr. Sojous, was recommended for chronic coryza:—

R.	Sodii salicyl,		2 dr.	
	Sodii bibor.,		3 dr.	
	Glycerini,		$\frac{1}{2}$ oz.	
	Aquæ,	ad	6 oz.	M.

Sig.—Of the above take 2 dr. and put into 1 pint warm water (100 deg. F.).

Of this latter solution, "snuff" into nostrils as much as can be taken up in the hollow of one's hand, *ter die*.

Prof. Bartholow advised, in a case of catarrh of the nares, of specific origin—

R. Sodii iodidi.	10 gr.	
Syrupi picis,	2 dr.	M.
SIG.— <i>Ter die</i> .		

Also—

R. Pil. ferri iodidi (U. S. P.)  
SIG.—One daily.

In the management of pregnancy, Prof. Parvin spoke as follows: Let the patient eat but little in the latter months, though she may eat a little frequently during the day. A large meal causes much inconvenience, due to the already enlarged abdomen. A bandage properly applied around the abdomen is useful and comfortable. She should sleep eight hours, and take an occasional bath in tepid water. If leucorrhœa be present, let her use an injection of salt water, and bathe the external genitalia with tepid water.

Care of the breasts. —Use oily matters, and no alcohol. In the morning the nipples may be painted with equal parts of tinct. arnica and water, but in the evening should be covered with cocoa butter.

High-heeled shoes should be dispensed with during pregnancy.—*Coll. and Clin. Record*.

## NOTES OF TREATMENT.

I. DYSPEPSIA.—*Causes of Functional Indigestion.* 1. Eating too rapidly. 2. Drinking too much water at meal time. 3. Improper food. 4. Want of exercise. 5. Too much tea and coffee. 6. Too much tobacco.

*Treatment.*—Under-done meats and but little bread. No sweets. Pepsin sacch., gr. v, at each meal. The mineral acids before meals, as muriatic, nitro-muriatic, or phosphoric. Certain bitters, as nux vomica and strychnine combined with gentian or calomba. An alkali a few hours after meals when there is great acidity, but should not be used too frequently.

2. DILATATION OF THE STOMACH.—*Treatment:* Dry, solid food; under-done meats; no milk. Carbolic acid to allay fer-

mentation. Wash out stomach occasionally. Strychnia, hypodermically or by mouth.

3. CHRONIC GASTRITIS.—*Treatment*: Cause to be removed. A scanty supply of food. Pepsin at each meal (gr. v). Milk, with a little meat, may be taken as food. Oxide of silver, gr.  $\frac{1}{2}$ , a dose, will be found of value. Bismuth is useful. Avoid tonics, but use the mineral waters to keep portal system drained.

4. GASTRIC PAIN (GASTRALGIA).—*Treatment*: Diet of little importance. Stimulus at meals in small amounts. Morphia relieves at once, but use it carefully. 1. Bismuth, with a little opium. 2. Nitro-muriatic acid, gtt. ij-iii, diluted, or—

R.	Morph. sulph.,		1-32 gr.	
	Acid carbolici,		gtt. j.	
	Aq. menth. pip.	ad	1 dr.	M.
SIG —Ter die.				

4. Fowler's solution, beginning with gtt. j, and increase to gtt. v, ter die.

4. HÆMATURIA.—Treat the cause as well as the symptoms, though the treatment of both is generally the same. 1. Gallic acid, in doses of gr. x-xx, repeated every hour or two. 2. Sulphuric acid, alone or with gallic acid, unless contraindicated by scarlet fever, etc. 3. Fluid extract of ergot, gtt. xx, increased to 1 dr. All three of the above are reliable remedies.

6. MEDICAL TREATMENT OF DIABETES MELLITUS.—Do not use bromide of potassium; it is valueless. Quinine is of no use. Opium is of value, and is one of the best agents, but care should be taken in its use. Codeia,  $\frac{1}{4}$ - $\frac{1}{2}$  ter die, is much used in France. Trousseau's plan, with strychnia, is very useful. The salicylate of sodium, gr. x-xv ter die, in compound spirits of lavender and water, is Prof. DaCosta's favorite. Ergot is useful, but less so than the others. The alkaliae plan, which is quite popular in Europe, is of value. Aloes or aloin should be used for constipation that may arise.

7. DIABETES INSIPIDUS.—*Medical Treatment*: 1. A course of iron, for its tonic effects. 2. Strychnia is very useful. 3. Ergot gives the best results; absolute cures follow its use;  $\frac{1}{2}$ -1 dr. of the fluid extract should be given ter die.—*Coll. and Clin. Record*.

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*The Medical Chronicle*, of Baltimore, will be merged into the *Medical Times*, of Philadelphia. Dr. Rhoe, of the *Chronicle*, will be on the editorial staff of the *Times*.



# THE PEORIA MEDICAL MONTHLY.

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THOS. M. McILVAINE, A. M., M. D.,  
*Editor and Publisher.*

204 S. JEFFERSON St., PEORIA, ILL.

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\*The Editor is not responsible for the statements or opinions of contributors.

\*Short original articles are invited from any reader, whether a subscriber or not.

\*If extra copies are desired by a contributor, the number must be specified when the article is sent to the Editor.

\*All exchanges, books for review, and communications must be addressed to the Editor and Publisher.

\*The publication day of this journal is on or about the 25th of each month.

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## EDITORIAL.

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### RULES FOR THE INTERNATIONAL CONGRESS.

At the special meeting of the revised committee on the organization of the Congress, held in New York September 3d, the following rules were adopted:

1. The Congress shall consist of members of the regular profession of medicine, who shall have inscribed their names on the register and shall have taken out their tickets of admission; and of such other scientific men as the Executive Committee of the Congress may see fit to admit.

2. The dues for members of the Congress shall be ten dollars each for members residing in the United States.

There shall be no dues for members residing in foreign countries.

Each member of the Congress shall be entitled to receive a copy of the "Transactions" for 1888.

3. The Congress shall be divided as follows, into seventeen Sections:

- I. General Medicine.
- II. General Surgery.
- III. Military and Naval Surgery.
- IV. Obstetrics.

- V. Gynecology.
- VI. Therapeutics and Materia Medica.
- VII. Anatomy.
- VIII. Physiology.
- IX. Pathology.
- X. Diseases of Children.
- XI. Ophthalmology.
- XII. Otology and Laryngology.
- XIII. Dermatology and Syphilis.
- XIV. Public and International Hygiene.
- XV. Collective Investigation, Nomenclature, Vital Statistics, and Climatology.
- XVI. Psychological Medicine and diseases of the Nervous System.

XVII. Dental and Oral Surgery.

4. The General Meetings of the Congress shall be for the transaction of business and for addresses and communications of general scientific interest.

5. Questions and topics that have been agreed upon for discussion in the sections shall be introduced by members previously designated by the titular officers of each Section. Members who shall have been appointed to open discussions shall present in advance statements of the conclusions which they have formed as a basis for the debate.

6. Brief abstracts of papers to be read in the Sections shall be sent to the Secretaries of the proper sections on or before April 30, 1887. These abstracts shall be treated as confidential communications, and shall not be published before the meeting of the Congress.

Papers relating to topics not included in the lists of subjects proposed by the Officers of the Sections may be accepted after April 30, 1887; and any member wishing to introduce a topic not on the regular lists of subjects for discussion shall give notice of the same to the Secretary-General, at least twenty-one days before the opening of the Congress, and such notices shall be promptly transmitted by the Secretary-General to the Presidents of the proper Sections. The titular officers of each Section shall decide as to the acceptance of such proposed communications and the time for their presentation.

7. All formal addresses, scientific communication and papers presented, and scientific discussions held at the General Meetings of the Congress, shall be promptly given in writing to the Secretary-General; and all papers presented and discussions held at the meetings of the Sections shall be promptly given in writing to the Secretaries of the proper Sections.

No communication shall be received which has already been published, or read before a society.

The Executive Committees, after the final adjournment of the Congress, shall direct the editing and the publication of its "Transactions," and shall have full power to publish the papers presented and the discussions held thereon, either in full, in part, or in abstract, as in the judgment of the Committee may be deemed best.

8. The official languages of the Congress shall be English, French and German.

In the meetings of the Sections, no member shall be allowed to speak for more than ten minutes, with the exceptions of the readers of papers and those who introduce subjects for discussion, who may each occupy twenty minutes.

9. The rules and programmes shall be published in English, French and German.

Each paper and address shall be printed in the "Transactions" in the language in which it is to be delivered.

All discussions shall be printed in English.

10. The President of the Congress, the Secretary-General, the Treasurer, the Chairman of Finance Committee, and the Presidents of the Sections, shall together constitute an Executive Committee of the Congress, which Committee shall direct the business of the Congress, shall authorize all expenditures for the immediate purposes of the Congress, shall supervise and audit the accounts of the Treasurer, and shall fill all vacancies in the offices of the Congress and of the Sections. This Committee shall have power to add to its membership, but the total number of members shall not exceed thirty. A number equal to one-third of the members of the Committee shall constitute a quorum for the transaction of business.

11. The Officers of the Congress shall be a President, Vice-Presidents, a Secretary-General, four Associate Secretaries, one

of whom shall be the French Secretary, and one of whom shall be the German Secretary, a Treasurer, and the Chairman of the Finance Committee.

12. The officers of each section shall be a President, Vice-Presidents, Secretaries, and a council.

13. The officers of the Congress and the officers of the Sections shall be nominated to the Congress at the opening of its first session.

14. The Executive Committee shall, at some convenient time before the meeting of the Congress, prepare a list of foreign Vice-Presidents of the Congress and foreign Vice-Presidents of the Sections, to be nominated to the Congress at the opening of its first session.

15. There shall be a standing Committee on Finance, composed of one representative from each State and Territory, the District of Columbia, the Medical Department of the Army, the Medical Department of the Navy, and the Marine Hospital Service.

The Chairman of the Finance Committee shall report to the Executive Committee of the Congress.

Each member of the Finance Committee shall appoint a local Finance Committee for his State, Territory, District, or Government Department, consisting of one or more members from each Government Department or Congressional District.

Each local Finance Committee shall report through its Chairman to the Chairman of the Finance Committee of the Congress.

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## STATE BOARD OF HEALTH STATISTICS.

The necrological report of the Secretary of the State Board of Health of Illinois, for the four years ending January 1st, 1885, shows the following points of interest.

During that period the death of 230 physicians has been reported.

Notwithstanding the severe demands such a life makes upon the physical man, two of the number lived four-score years and more; twenty-seven were over seventy; and 112, or about 50



per cent. were fifty years old. The average age was fifty-one years, the oldest being eight-two, and the youngest twenty-four.

As to the causes of death, it may be noticed: Affections of the respiratory system stands first with sixty to its credit, and twenty-four of these from pneumonia alone. Diseases of the digestive organs claim twenty-five. The circulatory and nervous systems each twenty, though of course many causes, as certain heart diseases, and even stomachic complaints often might be said to be primarily nervous rather than otherwise. Accidental causes record ten. So also ten from overdoses of medicines (almost universally these were soporifics). Of the remaining causes, perhaps the most notable is that six are suicides. C.

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### CHIEF OF MARINE HOSPITAL SERVICE.

For some time past there have been rumors of a change of the Supervising Surgeon General of the Marine Hospital Service, and Drs. Mathews, of Louisville, and Walling, of Indianapolis, have been mentioned in connection with the position.

A late dispatch from Washington City, however, states that Vice-President Hendricks has informed the President that in his opinion a change is neither wise nor expedient, and that he has withdrawn the name of Dr. Mathews whom he had previously urged for the place. It is said he will also oppose the appointment of Dr. Walling on the same grounds. The resignation of Surgeon General Hamilton has not yet been accepted, and the impression is, that he will be retained.

We hope this report is true, and that no change for political reasons will be made in the service. Dr. Hamilton has filled the office with honor to himself and credit to the service, and should undoubtedly be retained.

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### A WONDERFUL MAN.

Dr. N. S. Davis, of Chicago, is certainly one of the most extraordinary characters of contemporary medical history. Apart from his acknowledged abilities as a practitioner and teacher of medicine, his personal force and industry is almost unrivalled. With an extensive practice (said by many to be the

largest in the Northwest), and at an age when many would think of retiring full of honor and years, he is still the head of the American Medical Association, the Illinois State Society, the Chicago Medical College, the founder and editor of the *Journal of the American Medical Association*, and now has been appointed to the onerous duties of Secretary General of the next International Congress. Whatever criticisms may be made of his official utterances, no one can deny the wonderful energy of this wonderful man, and his name will long remain one of the noted names of American medicine.

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### OUR BUSINESS.

Readers are earnestly requested to send us short articles on any medical subject, reports of cases or therapeutic notes. We hope quite a number will comply with our request *at once*, that the October No. may be out on time with many original articles. We know of some on whom we can safely depend, and would like to know of more who will help us out "in a pinch" for matter. Many thanks to those who have remitted; there are yet several hundred delinquents, whom we would like to thank if they will only give us the opportunity.

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### NOTES AND COMMENTS.

Dr. Fehling, of Stuttgart, the inventor of the well known test for sugar in urine, died on July 1st, in his seventy-third year.

The honor of nobility has been conferred on the eminent surgeon, Dr. Richard Volkmann, Prof. of Surgery in the University of Halle.

A correspondent of the *Monthly Magazine of Pharmacy*, writing from Messina, says: "A bottle of bromine left in a closed room all night with the stopper out destroys all infection and insect life. I have cleared places which were infected with vermin many times. It is far more effectual than the vapor of burning sulphur.

Dr. Ralph Richardson writes to the *British Medical Journal* that any one may be cured of stammering by simply

making an audible note in expiration before each word. Stammerers can sing as easily as other persons. Jack Broster, of Chester, who made a large fortune by curing stammering, simply made his pupils say *her* before each word beginning with a consonant.

A countryman with a jumping toothache entered a drug store and inquired for something to give him relief.

"We have various remedies for that trouble," the druggist replied. "We can give you anything you like, sir."

"Well," replied the suffering countryman, "I guess you kin give me a small bottle of Boston faith cure; I hear it's knocking the spots off everythin.—*Gaillard's Medical Journal*.

Dr. Oliver Wendell Holmes says that a doctor's patients must put their tongues out, and a doctor's wife must keep her tongue in.

Doctor (*to patient*): "Well, how do you feel to-day?"

Patient (*in agony*): "Oh, doctor, do something for me. I suffer terribly. I have the pains of h—l."

Doctor (*in surprise*): "What! Already?"

In the Congo Free State are 4,500,000 people and only half a dozen doctors; at least so accounts state.

Dr. Partington, after reading of the wholesale withdrawals from the International Medical Congress as at present governed, was heard to remark sententiously, that he feared the Congress was likely to be merely a sexual one.—*Boston Medical and Surgical Journal*.

A druggist of Hoboken, Mr. Am Ende, well known in this city as a conscientious and enterprising man, put up ten grains of morphine in powders, instead of quinine as prescribed. The powders were taken by two young ladies of Hoboken, and both died from morphine poisoning. Thereupon Mr. Am Ende took a poisonous dose of atropine but recovered. The incident bears its own moral: That the most careful can sometimes make the most serious mistakes. There is room for the broadcast charity for Mr. Am Ende, as there is for the sincerest sympathy for the afflicted family.—*Medical Record*.

We learn from the *Lancet* that Dr. Keith, the well known ovariologist, has just returned from a short visit to America, whither he had been summoned to give his opinion upon a serious case. This is said to be the first instance, since the Declaration of Independence, of America having summoned medical aid from the old country.—*Canada Lancet*.

The consultation was held in Boston and Dr. K.'s fee is said to have been \$10,000. He agreed both in diagnosis and treatment with the attending physician.

Dr. P. O. Hooper, of Arkansas, President of the board of trustees of the State Lunatic Asylum, has been elected superintendent of that institution, *vice* Dr. C. C. Forbes, who has resigned on account of ill health. The appointment is a most excellent one.

Dr. Thomas Waugh, a physician of Chicago, Ill., was fatally shot on September 12th, while returning from a late visit to a patient. The assailant is said to have been a jealous husband.

It is certain that Bismarck's physician, though a charlatan, is no fool. It is related that when first presented the prince was sick, and peevishly declined to answer questions. "As you like," said the doctor, "then send for a veterinary surgeon, as such practitioners treat their patients without asking them any questions.—*Medical Record*.

In 1880 there were in the United States 64,137 lawyers, or one to every 782 people; 64,698 clergymen, or one to every 775; 85,671 doctors, or one to 585. Of these 214,506 professional brain-workers, there were 75 female lawyers, 165 female clergy, and 2,432 female doctors.

In 1784, the *Philosophical Transactions* recorded the case of a woman who had been tapped for ovarian disease eighty times, thirteen hogsheds and more being drawn from her during a period of twenty-eight years. So writes Dr. Waters in the *Medical Times*.

Physicians are accustomed to say that cocaine is a local anæsthetic. They are entirely mistaken. Any chemist will tell you that cocaine is methyl benzomethoxyethyltetrahydropyridinecarboxylate. Remember that the next time you have occasion



to mention the article in your medical society, but practice on the name a little before you wrestle with it in public.—*Detroit Lancet*.

Dr. C. A. Kingsbury, in *Amer. Jour. Dental Science*, says that probably no professional man, surgeon, physician or dentist, ever received the patronage of so many crowned heads, princes, nobles, and persons of distinction and great wealth, as the American dentist, Dr. Thos. W. Evans, of Paris. His fees have been fabulous, and the emoluments of his practice have been so large that his present wealth is estimated by millions.

“Behold! old things have passed away and all things have become new” in the treatment of menstrual suppression. Ring-er’s “English Bin-Oxide” has effected the transformation. Price, \$1.00. Clarke & Co., importers, 819 Arch St., Philadelphia, Pa.

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### BOOK NOTICES.

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INDEX CATALOGUE OF THE LIBRARY OF THE SURGEON’S OFFICE, U. S. A. Cloth, 4to. Vols. I–VI. A. to In. Government Printing Office, Washington, D. C.

This stupendous work will ever remain a monument to its projectors, and to the progressive genius of American Medicine.

A PRACTICAL TREATISE OF THE DISEASE OF CHILDREN. BY ALFRED VOGEL, M. D., Professor of Clinical Medicine in the University of Dorpat, Russia. Translated and edited by H. RAPHAEL, M. D., etc., New York. Third American from the Eighth German edition; with plates. Cloth, 8vo; pp. 640. D. Appleton and Company, 1, 3 and 5 Bond St., New York. 1885.

The numerous editions through which this work has passed in a few years, and the number of languages into which it has been translated adduces sufficient evidence as to its popularity and merit. It can safely be declared to be one of the standard works upon Paediatrics, and will continue to be such for many years to come.

We can give no better idea of the scope of the work than by giving the titles of the various chapters.

Beginning with a chapter on *Anatomo-Pathological observation upon the Infantile Organism*, it is followed by *General Rules for the Examination of Children*, and on the *Nursing and Care of Infants*. We have chapters on—*Diseases originating directly as the result of Delivery*. *Diseases of the Apparatus of Digestion*. *Diseases of the organs of Circulation, Respiration, Nervous System, Bladder, and Genital Organs*. *Eruptive Diseases*. *Miasmatic Biseases*. *Local Diseases of the Skin*. And finally, *General diseases of the Secretions*.

The style is that of an experienced teacher, plain and simple, never pedantic. The translator has done his work well, and the publishers have contributed no little share to the beauty of the volume.

**PRACTICAL THERAPEUTICS**—A compendium of selected formulæ and practical hints on treatment systematically arranged, interleaved and copiously indexed. BY EDWARD J. BERMINGHAM, A.M. M.D., etc., etc. Cloth, beveled boards, 8vo; pp. 420. J. R. Bermingham, 1285 and 1287 Broadway, New York. 1885.

As a general rule we do not look with much favor upon compilations of this kind, since they apt to cause the young practitioner to fall into the habit of "writing his prescriptions from a book," and generally, too, the formulæ are of very unequal merit. But in this instance we are forced to give an unqualified approval. After a close examination we have not been able to find a single formula that did not commend itself to our mind. The blank leaves afford sufficient space for the preservation of prescriptions or hints on treatment from journals, and the work can be made, if rightly used, of incalculable value to its owner. The press work, type, and binding leave nothing to be desired, and we predict for the work an extensive sale.

**A TREATISE ON NERVOUS DISEASES, THEIR SYMPTOMS AND TREATMENT.**—A Text-Book for Students and Practitioners. BY SAMUEL D. WEBBER, M.D., Clinical Instructor in Nervous Diseases, Harvard Medical School, etc. Cloth, 8vo; pp. 415. D. Appleton and Company, New York. 1885.

As stated in the preface, this book is not written for specialists, but for the use of students and general practitioners, and for

that reason alone it will prove of general value. It is divided into Diseases of the Brain, of the Spinal Cord, and of the Peripheral and Sympathetic Nerves, with a chapter on unclassified diseases, as Vertigo Chorea, Hysteria, Epilepsy, Tetanus, Syphilis, etc.

The author's style is concise and elegant, and his views are, so far as we are competent to judge, fully up to the times.

THE USE OF THE MICROSCOPE IN CLINICAL AND PATHOLOGICAL EXAMINATIONS. BY DR. CARL FRIEDLÄNDER BERLIN. Translated, with permission of the author, BY HENRY C. COE, M. D., Pathologist to the Woman's Hospital, New York. Second edition, 12mo cloth, pp. 190. D. Appleton & Co., 1885.

A few years ago the methods of the use of the microscope were exceedingly simple, but with the advances of the past few years, and especially in the field of vegetable parasites, the worker with this useful instrument must be exceedingly well posted to make his work of substantial value. This work is intended as a guide to the beginner, as well as a helper to the expert.

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### RECEIPTS.

The date following each name indicates where the amount credited extends the subscription:

ILLINOIS—Drs. W. N. Cline, (2.00), May, 1886; N. Holton, (2.00), May, 1886; D. T. Stewart (2.00), Feb. 1886; C. W. Durst (2.00), July, 1886; L. E. Keeley (2.00), May, 1886; Ch. H. Carter (2.00), May, 1886; J. H. Wallace (2.00), May, 1886; N. S. Tucker (2.00), August, 1886; S. B. Bennett (1.00), December, 1885; Julius Gunther (2.50) January, 1886; J. H. Tyler (2.00), May, 1886; J. H. Timkins (2.00), May, 1886; J. W. Hensley (3.00) May, 1886; J. P. Walker (3.00), May, 1886; R. R. Worthington (5.00), March, 1886.

TEXAS—Dr. J. F. Linden (1.00), September, 1886.

TENNESSEE—Dr. W. A. H. Coop (3.00), February, 1886.

KANSAS—Drs. D. C. Tyler (2.00), February, 1886; A. Puderbaugh (2.00), November, 1885; J. A. Mitchell (3.00), May, 1886; Jay H. Payne (3.00), September 1885.

OHIO—Dr. S. W. Mercer (1.00), October, 1885.

IOWA—Drs. Geo. McCulloch (3.00), March, 1886; J. B. Galer, (2.00), May, 1886.

# THE PEORIA MEDICAL MONTHLY.

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## ORIGINAL COMMUNICATIONS.

### OVARIOTOMY—DEATH.

BY O. B. WILL, M. D. PEORIA, ILL.

Mrs. K. a German woman, from near Orchard Mines, this county, of a vivacious disposition, twenty-nine years of age, and the mother of three children, was admitted to Cottage Hospital Aug. 11, with the following history: Six months ago she came in labor with the third child. So far as she was able to determine, the period of gestation had not been accompanied by any unusual feelings or premonitions except, perhaps, toward the latter part, the impression that she was carrying twins. Nothing abnormal had been detected previous to conception. A midwife attended her during the first stage of labor, but as the latter developed a tediousness and difficulty apparently out of proportion to the necessities of the normal condition, she prudently advised sending for a physician, and Dr. A. R. Warren, of Pekin, was summoned. He discovered the presence of a tumor about the size of a child's head at full term, and with considerable difficulty succeeded in extracting a living child. A very considerable hemorrhage followed, which was finally, however, gotten under control, and the patient slowly, though surely, regained a moderate degree of health. She resumed her domestic duties, but continued to feel rather weak. The tumor, which was located mostly in the left side of the abdomen, was from the date of labor continually prominent, and as time advanced grew with increas-



ing rapidity, filling the abnormal cavity and creating great distress by its size and weight, to say nothing of the accompanying chilliness, feverishness and increasing emaciation and debility.

Upon admission to the hospital she was found to be terribly weak and emaciated. The lower extremities presented the spectacle of the bones covered apparently by nothing but the integument. The veins were very much enlarged, as were also the veins of the abdominal parietes. The temperature of the body was almost continuously 102, and the pulse rate 120. The appetite was moderately good, the renal secretion about normal, and the bowels somewhat loose. An inspection of the abdomen, aside from the condition of the veins above alluded to, revealed the existence of a tumor of large size, projecting out prominently to the front, and distinctly presenting a double lobulated appearance which was still more marked upon palpation. The smaller lobe occupied the left iliac region, and the larger one the right center and more prominent portion of the abdominal cavity. For a short distance the sulcus between the lobes was somewhat sharply defined, but soon a firm and broad union was apparent. There was almost no mobility, but a semi-fluctuating condition was present. An introduction of the hypodermic syringe needle revealed the presence in the larger lobe of a clear, albuminous liquid—perhaps slightly cloudy. The introduction of the finger into the vagina disclosed a very dense, hard and utterly immovable mass in the hollow of the sacrum and posterior to the uterus and bearing a little more to the left than right. The cervix uteri was found high up behind the pubes and pressed closely against the latter. The introduction of the sound revealed a uterus of normal, or rather less than normal depth, and the introduction of the catheter located the bladder against the parietes of the abdomen, and pressed out like a fan, so to speak, between the latter and the anterior surface of the tumor.

In view of the fact that the woman was rapidly approaching the grave any way, and at her earnest solicitation, it was determined to attempt the removal of the mass by abdominal section.

August 17th the patient was etherized and placed upon the table. With the assistance of Drs. McIlvaine, Miller and Stout, and in the presence of a number of physicians of this city, I pro-

ceeded to the operation. The usual incision was made, extending from a point midway between umbilicus and pubes, to near the latter. The abdominal wall was found to be scarcely one-quarter of an inch in thickness and adherent in front to the surface of the tumor. The latter was cut into somewhat unexpectedly in consequence of its adhesion to the abdominal wall, the excessive tenuity of the latter and the paper-like thinness of the parieties of the tumor itself. The wall of the growth was very vascular, its internal surface being well supplied with enlarged arteries and veins which bled very profusely upon severance, but defied any attempt to ligate on account of extreme friability of their own structure as well as the surrounding tissue. The incision was speedily enlarged upwardly, both in the wall of the abdomen and that of the tumor, and the contents of the larger section of the latter removed with the hand. They were found to consist of a jelly-like, or thick, semi-transparent material mixed with both venous and arterial blood, and enclosed in separate compartments, of varying size, easily broken into. After emptying the tumor as much and quickly as possible, the abdominal incision was still further enlarged near the umbilicus, and an attempt made to break the adhesions and turn the remainder of the tumor out. The adhesion to the wall in front was found to be neither very extensive nor very firm, and was soon broken up; but that to the omentum was very considerable and very firm. The only way to separate the surfaces was to tie the connecting tissues with fine silk and cut them through with the scissors, and it was accordingly done. With some difficulty the tumor was then turned out, the smaller section, or lobe, being hard and resisting and completely involving the right ovary and broad ligament. The uterine extremity of the broad ligament and its contents was comparatively free and formed a very inviting pedicle. It was transfixed by a stout handled needle, carrying a good-sized silk ligature, and the latter tied in the manner designated as the "Staffordshire knot." Upon the severance of the pedicle by the scissors no oozing of importance was discovered in that locality, and what there was from the other surfaces was soon suppressed by the application of sponges wrung from very hot water. The abdominal cavity was finally well sponged out, the intestines re-

tained as nearly as possible *in situ* by a large flat sponge laid over them and inside of the abdominal walls, and the wound closed by interrupted silk sutures in the usual manner. A large pad of cotton held on by a broad bandage and covering a carbolized oil dressing completed the operation, and the patient was placed in bed and surrounded by bottles containing hot water. She was so much exhausted that the idea prevailed she would never get off the table alive; and indeed she was several times supposed to be dying. She rallied, however, under the use of injections of brandy, and some hours after being placed in bed reaction seemed to be pretty well established, and she rested in tolerable comfort except for the vomiting which continued to follow the administration of the ether in the first place. This was the trying symptom throughout. The patient was warm, cheerful, and had a desire for food but was unable to retain it for more than a few minutes. The urinary secretion was approximately normal in quantity and quality, the bowels moved with as much freedom as could be expected, in response to repeated injections, and only a moderate degree of tympanitis developed. The temperature never rose above 102 during the progress of the case, and but little pain was complained of, excepting in the back, which, on account of the extreme emaciation, was very sore, even approaching to abrasion. In spite of the use of nearly every means to be thought of, the vomiting continued at intervals of from ten minutes to an hour. The agent which proved of greatest value and gave most relief was iced champagne in doses of one-half to one teaspoonful every fifteen minutes. The patient continued to reject all nourishment, gradually grew weaker and died of exhaustion on the fifth day.

An examination of the tumor after its removal revealed the fact that it was primarily of a dermoid character. The smaller lobe, which was located in the sacral concavity, and was felt as an extremely hard body posteriorly to the uterus, was found to be a dense, fibrous sack, with parietes nearly or quite an inch in thickness, enclosing several tufts of blonde hair several inches in length, and surrounded by a cheesy matter. To the upper and right side of this smaller lobe was attached the larger one, consisting of a thin membranous sack divided into various com-

partments, adherent to the sides of which, as well as to the inside of the sack proper, was the peculiar thick, jelly-like substance formerly referred to, and the most of which was removed by the hand previous to turning out the tumor.

Thus, briefly, I present this case to the consideration of the profession. The essential points in connection with it have, I think, all been given, and nothing would be gained by a resort to minor details. The two features to which I would ask the attention of the thoughtful reader are, first, the strong probability, as developed in the history and progress of the case, that an earlier operation would have proven successful, and, second, the uncontrollable vomiting and its influence in compelling a fatal issue.

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## A CASE OF PLACENTA PRÆVIA AND ITS SEQUELÆ.

BY WM. A. JAMES, M. D., HARRISONVILLE, ILL.

Mrs. E., age 32, of very slender build and inclined to be delicate, had a slight uterine hemorrhage on May 7th, 1885, which she supposed was due to lifting a stove boiler full of water. The hemorrhage was repeated twice or three times up to June 12th, but was controlled each time by rest in bed and Squibb's fl. ext. ergot.

I was called to see her on the 12th of June. There was a pretty free hemorrhage from the uterus, and on making an examination, I found the os dilated to the size of a silver quarter, soft and patulous. The head was presenting as it should, but the placenta was attached to the left posterior wall of the uterus and within half an inch of the os. I could insert my finger under the edge where it had been torn loose. There was some malarial fever also, the temperature ranging from normal to 100, and the pulse never under 100. I prescribed cinchonidia sulph. in 3-grain doses every three hours, and 15 drops of ergot three times a day and confined her to her bed.

Saw her three or four times between the 12th and 26th. There was an occasional hemorrhage when she would move too much in bed.



I was called again to see my patient on June 26th, at 9 A. M. Found the os dilated to the size of a half dollar, with pretty strong uterine pains and some hemorrhage. I watched the case about two hours when the pains became less and seemed as though they would cease intirely. I decided, as labor had commenced, and my patient growing weaker day by day, to hasten the delivery. I gave 10 drops of ergot every fifteen minutes to increase the pains and control the hemorrhage. She had a severe chill at 12 M., which arrested the pains for a time. It was of short duration, lasting only a half hour, when the pains returned and I made the doses of ergot farther apart. At 1:30 P. M. the temperature was 100 and the pulse 110. At 2 she was delivered of a very small female child, about the eight month and weighing 2¾ pounds. The loss of so much blood and the weakened condition of the patient probably caused the lack of developement of the fœtus. It lived until 10 P. M., June 27th.

After waiting a half to three-quarters of an hour and using external manipulation to deliver the placenta, I made an examination and found I had an adherent placenta to deal with. This being the fourth pregnancy and more or less adhesions each time, I decided to delay no longer. It was so firmly attached to the uterine walls that it required twenty minutes or a half hour to deliver it. I got a firm contraction of the uterus after the placenta was removed, which checked all hemorrhage, but she began immediately to sink, which was caused by the loss of so much blood and shock in delivering the placenta. She would complain every few minutes of "feeling so badly." When asked where she felt so badly, she could not tell only she "felt so badly." She continued to grow weaker with sighing respiration and profuse, cold perspiration, so much so that it would dampen a large towel in wiping the face twice. I gave her 5 drops of ergot and a half teaspoonful of brandy every half hour and 2½ grains cinchon. sulph. every 3 hours.

At 6 P. M. the pulse was 160; at 6:30 I was not able to count it; at 7 it was a little stronger and continued to gain a little strength during the night. At 2:30 A. M., June 27th, Dr. Wetmore, of Waterloo, arrived in consultation. He added bromide of ammonium, as she was not resting well and tr. digitalis to steady the heart's action, but thought the case hopeless.

June 27th, 7 A. M.—Pulse 140 and less perspiration, also resting better. 4 P. M.—Pulse 120 and a little feverish, with a great deal of thirst. Made the doses of ergot farther apart: other treatment the same as before except less of the brandy.

June 28th, 9 A. M.—Pulse 115, temperature 102; patient had a high fever during the night with great restlessness and delirium. The skin was a little moist, tongue dry and heavily coated. Made the cinchonidia 1 grain and added 1 grain of Dover's powder every three hours: other treatment the same. 9 P. M.—Pulse 107, temperature 101.5; skin moist and tongue also; slept most of the day; had the vagina syringed out with a half gallon of warm water and carbolic acid twice a day; each time after using the syringe had the external genitals well coated with carbolized oil; continued the injections twice a day for a time, then once a day for the first two weeks, when the lochial discharge gradually ceased. At no time was the odor more offensive than I have seen in a natural labor during such warm weather.

June 29th, 10 A. M.—Pulse 104, temperature 100.5: rested well during the night. 5 P. M.—Pulse 108, temperature 100.3: continued the same treatment.

June 30th, 10 A. M.—Pulse 115, temperature 99.5. All symptoms good.

July 1st, 10 A. M.—Pulse 110, temperature 99: rested well during the night; bowels moved three times from small dose of sulph. magnesia; passed plenty of urine and all other symptoms first rate.

July 2d, 11 A. M.—Pulse 115, temperature 101.5. My attention was called to two large bed sores on the back, involving the upper portion of the nates and nearly uniting in the center over the sacrum. They were probably two inches in diameter with a half inch of sound tissue between them. There were two pieces of dead tissue an inch and a half in diameter lying in each sore. I could not tell how deeply they extended. I ordered carbolized oil (1 to 20) to be used freely and to keep off the back by lying first on one side then on the other.

July 3d, 10 A. M.—All symptoms the same as the day previous, except the back. She still persists in lying on it. Had a ring prepared to protect the back, but she would not use it.

July 4th, 10 A. M.—Pulse 64, temp. normal.

July 6th, 10 A. M.—Pulse 110, temp. 99. The bed sores not improving.

July 8th, 10 A. M.—Pulse 108, temp. 100. The sores continue to slough, the two now uniting and the dead tissue in the centre beginning to separate. I ordered powdered burnt alum to be dusted on once a day and continue the carbolized oil.

July 10.—The same as on the 8th. Continuing the same treatment.

July 11th.—Troubled some with dysentery. Prescribed opium, bismuth subnit. and prepared chalk.

July 12th.—The dysenteric symptoms improving. The back is no better. The dead tissue separating and coming out. Still persists in lying on the back.

July 13th, 10 A. M.—Pulse 125, temp. 101.5. Dysentery a great deal worse, having had ten or twelve stools in the past twenty-four hours; two were passed involuntarily in bed. The tormina and tenesmus annoying her very much. Prescribed  $\frac{1}{8}$  gr. morph. sulph., 10 gr. bismuth subnit. and 5 gr. prepared chalk in addition to 5 gr. each of cinchonidia sulph. and Dover's pwd. every three hours.

July 14th.—Continued the same treatment. Bowels no better. Some symptoms of pelvic cellulitis. The sore on back continues to slough and grow larger.

July 15th, 10 A. M.—Pulse 120, temp. 102. Prescribed the following for the dysentery with the cinchonidia and the Dover; dropping the morphia.

R.	Bismuth subnit.		
	Creta prap.	aa.	160 grains.
	Ingluvin (Warner's)		1 drachm.
	Ext. rub. rad. fl.,		$\frac{1}{2}$ ounce.
	Tr. opii camph. qs. ad.		2 ounces, M.

Sig.—Shake well and give a teaspoonful every three hours.

July 16th, 10 A. M.—Pulse 120, temp. 102. Dysentery better, but some phlegmasia dolens of the right leg. I bandaged it and gave  $7\frac{1}{2}$  gr. doses of iodide potass., three times a day. Using iodoform freely in the sore on the back, with the carbolized oil. The sore was now six inches by three and one-half, running transversely across the back and exposing the spinous

processes of the sacrum, also destroying a large portion of the gluteus maximus muscle on each side. It had become so painful that she could not lie on it any longer.

July 17th, 10 A. M.—Pulse 110, temp. 100.4. Bowels are a great deal better and all other symptoms improving.

July 18th, 10 A. M.—Pulse 118, temp. 100.1. Still improving.

July 19th, 10 A. M.—Pulse 120, temp. 101.

July 20th, 10 A. M.—Pulse 120, temp. 100.4. The bowels are inclined to be a little costive.

July 21st, 10 A. M.—Pulse 120, temp. 100.8. Back healing nicely.

July 22d.—Pulse 120, temp. 100.

July 23d.—Pulse 120, temp. 99.6.

July 24th.—Pulse 120, temp. 100.2.

July 25th.—Pulse 120, temp. 100.

July 26th.—Pulse 120, temp. 99.

July 27th.—Pulse 125, temp. 99.8.

July 28th.—Pulse 125, temp. 99.5.

July 29th.—Pulse 125, temp. 99.5. There was some delirium and muttering in the sleep during the night. Did not rest well.

July 30th.—Pulse 130, temp. 101.4. Patient continues to grow worse, getting more stupid and hard to rouse up, but still not sleeping. Continued the cinchon. sulph. with 1 gr. of Dover every three hours and added tr. digitalis and tr. lobelia aa. 5 drops every two hours.

July 31st.—Pulse 204, temp. 99.8. Other symptoms a little better.

Aug. 1st.—Pulse 92, temp. 98.8. Still delirious and restless. Continued the same treatment with an abundance of nourishment, which I had given from the beginning of the case.

Aug. 2d.—Pulse 96, temp. 99. More delirious and restless.

Aug. 3d.—Pulse 110, temp. 100. Sinking, can hardly swallow.

Aug. 4th.—Pulse 130. Getting still weaker.

Aug. 5th, 9 A. M.—Dying. Pulse a mere thread. Died at



4 P. M. from pyæmia, the pus being absorbed from a pelvic abscess which opened through the vagina after death, discharging more than a pint of very offensive pus. There was no complaint of any pain or soreness to indicate that the abscess was forming, except in the last few days, when she complained once or twice in her delirium of it hurting her in two places.

What caused the pelvic abscess? Was it the product of the pelvic cellulitis or was it metastasis from the bed sore? Dr. Wetmore is inclined to the latter view and the circumstances bear out his conclusions. First there was a very small amount of pelvic cellulitis and if it had been from that, there should have been more pain and tenderness longer continued, and the temperature should have run higher than it did. Second, the bed sore was discharging pus pretty freely within a few days of the first pyæmic symptoms. Now, the ulcer could not have ceased producing pus so suddenly, so it must have been taken up by the blood and deposited in the pelvic region.

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### QUINIA BY INUNCTION.

BY WM. W. MOORE, M. D. WARREN, MO.

About one year ago I was called to see two children, one five and the other seven years of age, both suffering with malarial fever of a remittent type. I prescribed calomel and podophyllin in small doses every three hours until free catharsis was induced, alternating with liberal doses of quinia. The little five-year-old boy took his medicine without any grumbling, but the combined force of her parents, supplemented by the nurse's and my own efforts, failed to make the little seven-year-old girl swallow the medicine. Finding myself completely balked, I was non-plussed as to how I should proceed as it was plain that we could not force her to swallow, and the parents were unwilling that such a terrible struggle should be gone through with at the repetition of each dose. While thinking about the advisability of a blister sprinkled with quinia the thought obtruded itself, "Why not try inunction?" No sooner thought than done.

Calling for some lard I incorporated a large quantity of quina with it, at least three or four times as much as I should

have given her in twenty-four hours, with directions to rub one-eighth of the mass thoroughly every three hours over the abdomen and inner surface of the thighs. I should have stated that the symptoms in the little girl were of far greater severity than those of her brother. I left promising to be there at the same hour the next day.

Judge of my surprise, when upon my return I found the patient without fever and getting along nicely. I prescribed the same treatment for the next twenty-four hours. I found her little brother with fever yet although the remission was well marked. I went back on the third day and found the little girl convalescing rapidly, while the little boy, who continued to take his medicine *per oram*, ran on until the fifth day before his fever "broke." I have had occasion twice since then to resort to the same method, each time with like result, although not quite so promptly.

My success in those cases has led me to infer that inunction would be a good plan to resort to in some of those cases that manifestly need quinia, but, from an irritable or weak stomach it cannot be borne. There are many, many cases in every man's practice in which I opine, used in this manner, it could be made to fulfill the indications for its use.

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## BILIARY CALCULI.

BY F. B. BATCHELDER, M. D. LYONS, IOWA.

An interesting case of biliary calculi recently came under my observation, which may be of interest to some of your readers.

On April 21st, 1885, I was called to see Mrs. L., a German lady, aged 43 years, mother of ten children, the youngest 14 months old, from whom I obtained the following history: She had always been healthy, excepting that on several occasions, about an hour after eating, she had experienced a sharp pain in the region of the stomach, which was quickly relieved by taking a liquid prepared for her by her physician. At her last confinement she had been attended by a midwife. First and second stages of labor were normal. The midwife removed the placenta

by traction on the cord without waiting to give nature a chance to finish her work. The patient assisted by making strong expulsive efforts. As the placenta was removed the patient felt a sharp pain in the right hypochondriac region radiating upwards into the shoulder and cervical region.

Notwithstanding that this pain continued, she left her bed as soon as usual for her, probably about the third or fourth day. From her confinement till I saw her she had never been free from the pain, although she had persevered in attending to her household duties. She had consulted three or four physicians but had received no benefit. At the time of my first visit her condition was about as follows: Temperature, 101 degrees F.; pulse, 60; tongue covered with a thick, yellow fur, mouth sore, gums swollen with constant dribbling of saliva, breath very offensive to the smell, bowels constipated, stools clay colored, urine scanty and almost blood red, profuse night sweats and the most extensive jaundice I have ever seen, liver somewhat enlarged and extremely tender, and a large hard tumor over the region of the gall bladder, stomach so irritable that nothing would remain on it—not even water—thirst excessive, no appetite, intense headache. My diagnosis, of course, was jaundice from obstruction of the bile duct, though what caused the obstruction I was unable to say. I immediately put her upon the following:

Hyd. chl. mit.,	1 grain.
Sodae bi carb.,	25 grains.
Podophyllum,	1 grain.
M. et div. in chart No. 12.	

Sig—One every three hours during the day.

Gave her a Seidlitz powder every other day. She improved steadily so as to be able to sit up in a few days, take some nourishment, headache disappeared, also soreness over the liver, I will here state that I applied mustard plasters over the liver for counter irritation. The jaundice remained and the clay colored stools. I ordered tepid baths every alternate day in which sodium bicarbonate was dissolved. After about three weeks of this treatment, and when I began to be discouraged about ever relieving the jaundice and had begun to suspect some malignant trouble in the stomach or intestines involving the bile duct, she told me she had had a passage from the bowels of natural color.

I told her that was good news and I thought her trouble was about over. The next day I was hurriedly summoned to her bed side, the messenger stating that he thought she was dying. When I arrived I found her writhing in terrible agony and vehemently stating that she could not hold out any longer, she was dying and wished me to give her something that she might pass away easily. I immediately recognized the symptoms of gall stones, and the cause of the jaundice now being clear, I gave her a hypodermic injection of morphia and atropia and when she became quiet, left her, telling the family that she would probably be all right in a few hours. On calling the next day found her feeling quite comfortable, and what was my surprise on her producing a paper in which was carefully wrapped a gall stone about the size of a pea. From its shape I felt sure there had been others with it which had either escaped detection or remained in the gall bladder. Subsequent events demonstrated the correctness of this view as she has had three other attacks of pain and has passed in all 98 gall stones, passing in one day as high as 33 of these concretions. The weight of the entire collection is 280 grains. She has now apparently recovered her former good health and the jaundice has entirely disappeared. These concretions are formed in layers and are easily cut with a knife. My theory in regard to the case is that the calculi had been forming for years till the gall bladder was nearly filled up, and when the woman bore down to assist in the expulsion of the placenta the pressure of the muscles of the abdomen drove one of the calculi into the bile duct thus occluding that passage and producing the jaundice.

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### RHUS TOXICODENDRON.

BY SILAS HUBBARD, M. D., HUDSON, ILL.

In the August number of the MONTHLY is an original article on the above subject. I have found by experience that the remedies therein mentioned are good for the curing of the poisoning. The remedies are of a parasiticide nature. I find that parasiticides are the best remedies for the rhus poisonings. Besides the remedies mentioned in the aforesaid article I have applied fre-



quently a strong infusion of stramonium leaves with good effect. I have also frequently had the patient bathe the parts affected a long time with very warm water with good effect. And now as I have spoken of parasiticides I would say that I am inclined to believe that the poisoning from the rhus comes from a specific parasite that infests the rhus, and that making a tincture, or decoction of the rhus would kill the parasites and thus render it innocuous, whatever other properties it possesses. I make the foregoing suggestions in hopes that microscopists will examine the fresh leaves of the rhus from the 1st of July till the 1st of September (that being the time they seem the most virulent), and report the result of their examination.

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## TO REMOVE GELATINOID POLYPUS FROM THE NOSE—COUGH—DIABETES.

BY R. L. MOORE, M. D., SPRING VALLEY, MINN.

Proceed the same as for plugging posterior nares for hemorrhage, only have a strong cord, and a large, coarse cotton plug. Pull the plug clear through until it and the polypus come out of the anterior nares.

In cough mixtures add glycerine and syr. rhei, arom, and your patient will bless you.

In diabetes use equal parts of ergot and the best fl. ext. hammelis, in teaspoonful doses for an adult, three or four times a day.

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## SOCIETY TRANSACTIONS.

### CHICAGO MEDICAL SOCIETY.

Stated meeting, September 21, 1885. The President, C. T. Parkes, M. D., in the chair.

"Special versus General Study in Medicine" was the title of a very interesting essay by Dr. Charles F. Sinclair. The following is an abstract: During the seventeenth and eighteenth centuries there existed several schools of medicine founded upon medical investigations stimulated by the discovery of the circulation of the blood by Harvey. These schools were founded upon theories. One school explained the processes of life as due to

mechanical laws; still another, as due to molecular movements; and finally, schools were founded who respectively promulgated the doctrines that life was due to an ether or a spirit existing in the grosser material of the body. Thus we see that medical thought and investigation began to divide. This subdivision in thought led to separate investigations, and specialism was the result. This tendency, which is becoming more marked each day, may be called, perhaps, the distinguishing characteristic of recent medical study. The more clearly defined and generally recognized specialties to-day are surgery, diseases of the eye, diseases of the ear, diseases of women, diseases of children, diseases of the skin, diseases of the nervous system, diseases of the genito-urinary tract, including syphilis, diseases of the throat, heart and lungs, obstetrics and forensic medicine. The rapidity with which the tendency of special study is being developed is seen in the fact that five years ago one of our oldest medical schools gave special notice of only two of the special subdivisions I have mentioned. However, within three years this school has added a fourth year for the study of the branches mentioned. But it is objected that the student of a specialty should become practically conversant with the details of so-called general medicine. But it is a disastrous step for the young practitioner to try to cultivate a special practice from a general, if the old adage, "Once a general practitioner, always a general practitioner," is true. On the other hand, the specialist gains a footing more readily by confining himself to his specialty. It is further objected that the specialist is apt to forget that there are other important organs in the body beside the one to which he has given his attention. But this objection is puerile, when it is seen that the successful specialist must of necessity study the relations the different organs of the body hold to each other, and remember that any departure from the normal in one organ may be the result of disease in a more remote organ. The medical profession should look with favor upon this subdivision of medical work, because we see such vast accumulations of material in all the various departments of medicine that few would care to undertake or have the ability, to even peruse our medical literature, much less master all the knowledge collected. In this day of rapid in-

terchange of thought none can be found who can keep abreast of all the discoveries in the various departments of medicine. Another reason for the existence of the specialist is the fact that very few men can secure the expensive instruments necessary to be used in the treatment of the various diseases, nor are there many physicians who could skillfully use them were they so fortunate as to possess them. Many cases cannot be successfully treated without these instruments. In our city, specialties should receive further development, because as they are clearly defined and faithfully adhered to in practice, proportionately does the city rank as a medical center.

Dr. F. M. Weller opened the discussion by asking why the subdivision of the practice of medicine into the special treatment of diseases of the various organs should not be carried further into specialties for various specific diseases? Let us have physicians whose respective specialties shall be catarrh, ague, diptheria, etc.

Dr. W. F. Coleman said that while he agreed with the author in the main points in his paper, he thought it should rest with each individual whether he shall confine himself to special practice or emphasize it in general practice. It is advantageous to specialists that they should confine themselves to their chosen fields. But we should not judge of the benefits to be derived from specialties by the individual success of each practitioner, but by the extent each practitioner enriched our literature by the record of his investigations. It is thus that the eye and ear specialist, the specialist in throat and lung diseases, the laryngologist and others have done most to advance medicine.

"The Treatment of Syphilis" was the title of a paper read by Dr. L. T. Potter. He said that the treatment of syphilis must be threefold—hygienic, tonic and specific. By the latter is meant the administration of mercurial and iodine preparations. The profession seems to be greatly divided in opinion in regard to the methods of using these remedies and the length of time they should be employed. In scanning the literature on this subject the reporter was surprised to find that those high in authority differed as to these points. The reporter advanced two propositions: first, that neither the iodine preparations alone, nor mer-

cury alone, can always be relied upon as effective in the treatment of syphilis, but that *both* are necessary to eradicate the disease: second, that the duration of treatment must be at least two years, faithfully carried out, no matter how mild at attack. In support of his first proposition the reporter quoted Bartholow, Ringer, Jonathan Hutchinson, Keyes, Bumstead and Taylor as saying that mercury should be given in the primary and secondary stages of syphilis, and iodide of potassium in the tertiary stage. They all agree that both must be used to effect what is called a cure. In support of his second proposition, he quotes VanBuren and Keyes, Fournier, Bumstead and Taylor, as insisting upon the treatment extending over a course of two years or more. Diday says the minimum time for treatment is twenty-two months. The two-year course of treatment does not mean the continual administration of mercury or iodine, but at intervals the remedy may be discontinued for a short time, if it seems to have a debilitating effect on the patient. In the light of such unanimity of opinion of eminent authorities upon this question of duration of treatment, it is surprising that intelligent physicians will positively assure their patients that they are *cured* of syphilis at the expiration of a course of treatment lasting from four to six months !! A physician who does so is certainly criminally negligent, and is a misanthrope of the worst type. Then it becomes all to impress upon patients the importance of carrying on the treatment for at least two years.

Dr. E. L. Holmes commenced the discussion by saying he considered the paper very valuable, because the author lays so much stress upon the importance of thorough and long-continued treatment. One of the most important lessons he had ever received was to treat syphilis according to the plan the gentleman has advocated. Many years ago he had been taught this lesson by sad experience. It had been his lot to see many patients suffering from specific diseases of the eye long after they had been discharged by their physicians as cured. He could not understand how any physician can believe it possible to cure syphilis without carrying out the treatment a long time. In many years' practice in this city he cannot remember of having seen but three primary syphilitic lesions, and these all occurred on some por-



tion of the eye. He saw one man who had on the upper eyelid a sore which resembled and was treated as a burn, until its course decided it to be a chancre. The man would not tell how he obtained it, but it readily disappeared under specific treatment. A great many diseases of the eye occur thus, and the physician is unable to find out how they arise. Many years ago it was taught that iodide of potash, if given in large doses, would effect a sure and speedy cure. But Dr. Holmes thought the treatment by large doses of iodide dangerous, as it ameliorates the symptoms so quickly as to cause the physician and patient to abandon the remedy too soon. In this country we do not have so good an opportunity to study syphilis as the Europeans. In Vienna and Prague, where the people live and do not pass from the observation of physicians, their statistics are more valuable and reliable than ours can be. He thought it best to give the patient all the mercury he can bear in the primary and secondary stages. Rub it in the skin and give it internally. Follow this up eighteen months or two years, and then give iodide of potassium later. Every three or four months give a course of treatment for years after. You will have no trouble impressing upon intelligent people the importance of long-continued treatment.

Dr. R. Tilley said he wished to refer to one point not touched in the paper, and that is, patients treated for syphilis are often told by their physicians of the importance of long-continued treatment, but they will not heed these warnings, and do not return. This fact will excuse the physician many times, as it is not in his power to carry out the treatment when he wishes; and thus physicians should often be relieved of the blame of not having treated their patients long enough. He did not think any intelligent physician would advocate treatment under two years, and he believed Keyes, in his last edition, extended the time of treatment to four years. Dr. Tilley was of the opinion that we cannot do without mercury, and yet some of the high places teach this doctrine. Those who try to treat syphilis without mercury are certainly responsible for later developments.

Dr. J. Zeisler thought the present treatment of syphilis is not scientific, and that there had been little advance in this direction in the last century. Cases are known in which, after seven

years' treatment, symptoms of the disease returned. Take the case of Prof. Zeissl, who died last year. He was infected while opening a bubo several years ago. He certainly knew how to treat himself, and yet he died of cerebral syphilis. This does not look as though the treatment of syphilis is yet founded on a scientific basis. If the discovery of the bacillus of syphilis proves to be correct, it may prove the means of enabling us to treat syphilis scientifically.

Dr. G. C. Paoli said he is by nature a cosmopolitan, and always selects the best from the writings of all nations. A great many books have been written on this subject, among which Ricord's stands first. Ricord was a man of great talent, experience and powers of observation. He had unexcelled opportunities for study in the Paris Hospital when he was the chief physician. In regard to treatment, all agree that mercury must be administered for a long time. There are syphilitic cases in which mercury is contraindicated, namely, phthisical patients and in albuminuria, unless we believe syphilis is the cause of the albuminuria.

Dr. R. Tilley referred to one point introduced by Dr. Zeisler, who referred to Prof. Zeissl as having died of cerebral syphilis, claiming that no one would doubt Prof. Zeissl's ability to cure syphilis. But the question is not whether Prof. Zeissl knew how to treat syphilis, but how did he treat himself? Cooper, in his book on syphilis, if he (Dr. Tilley) were not greatly mistaken, cites Prof. Zeissl as a type of those who used mercury sparingly. If that is so, and Zeissl used it only sparingly on himself, then the death of Zeissl from cerebral syphilis is a very important lesson, and bears materially on the subject under discussion.

Dr. J. Zeisler said he knew that in the case of Prof. Zeissl mercurial inunctions were made, but to what extent he was unable to say.

Dr. L. T. Potter closed the discussion by expressing himself as gratified at the amount of discussion which had been aroused; however, he was surprised at the statement that there had been little or no advancement in the treatment of syphilis. In this day of elegant pharmaceutical preparations and easy ad-

ministration of mercurials and iodides, he thought there had been a great advancement, for pharmacy and chemistry have stepped in and given us preparations we did not use many years ago. Mercury should not be given when it is producing a debilitating effect.

The President, Dr. C. T. Parkes, presented to the society a specimen, with the following remarks: "I hardly know whether you will call this a pathological specimen or not. But you see a mass which was removed from a uterus, and proves to be a sponge. A short time ago I was called to see a lady who had been treated by a physician who introduced a sponge tent into the cervix uteri, and instructed the lady to allow it to remain two or three days, and then pull it out. She attempted to do so, but the string broke and the sponge was not obtained. After three weeks of suffering, with a discharge per vaginam, I was called to see her. By digital examination I could not find any evidence of the sponge, the external os being closed so as to merely admit a probe. But I could not find any sponge by probing, so I introduced an Ellinger dilator, and soon seized the sponge with a forceps and brought it out. The symptoms present passed rapidly away, and the patient is now well. The point to be learned is, that when a physician introduces a sponge tent, he himself should remove it.

The society then adjourned.

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### CHICAGO MEDICAL SOCIETY.

Stated meeting, October 5, 1885, the President, C. T. Parkes, M. D., in the chair.

Intubation of the Larynx, with a Report of Five Cases, was the title of a paper read by Dr. F. E. Waxham. The paper was supplemental to one read before the society on April 20th, in which the operation was minutely described. Dr. Waxham exhibited a larynx with the tube in situ. He described the manner of performing the operation, as follows, by the nurse holding the child in her lap, with the hands at the side, an assistant firmly holding the head backward. The mouth is held open by a gag placed on the left side between the teeth. The tube, armed with

a silk bridle, well waxed, is now secured to the introducing instrument. The right hand manipulates the instrument, while the index finger of the left hand guides safely and quickly the tube over the epiglottis into the larynx, when the introducing instrument is removed and the tip of the finger presses the tube well down into the larynx. We make sure the tube is in proper position by the easier breathing, the tube remaining stationary, and by coughing on the patient attempting to swallow water. The bridle of silk is apt to produce violent coughing, and is generally removed. The latest improvements in the tubes consist in an enlargement of the head of the tube with a backward curve, preventing the tube from slipping into the trachea and allowing the epiglottis to fall during the act of deglutition. There is also an enlargement in the center of the tube, allowing it to be more easily extracted. Dr. Waxham reported in detail five cases of croup treated by intubation. One case recovered, one died six days after intubation from pneumonia; the result of unfavorable surroundings. The other cases were not such that recovery could be definitely expected. Dr. Waxham then presented the history of the five cases in detail, after which Dr. H. T. Byford opened the discussion by saying he had the pleasure of seeing the case reported in which there was a complete recovery. In the contrast between this operation and tracheotomy there are many points in favor of intubation, and there are not many cases in which tracheotomy is indicated that intubation is not, one of its chief advantages being its simplicity. The first case of tracheotomy he had ever performed was a success and gave him a great deal of encouragement, but the next was such a terrible case, and a failure, that he was discouraged. He had assisted at several tracheotomies, but the difficulties of the operation, the trouble of overcoming the prejudice of the parents against the operation, and the difficulties and bad results following, had caused him to abandon the operation as of little use except in good cases. But when he saw this case, with all the absence of numerous attendants and paraphernalia in the after-treatment, and the comfort and freedom of the patient, he was greatly astonished. The simplicity and safety of the operation and the comfort afterwards; the fact that the consent of the parents can



be easily and early obtained, that failure to relieve will not bring discredit upon the physician, and that the tube opens in the throat instead of the external air, leaves no doubt in his mind that intubation, whenever it can be successfully accomplished, will supersede tracheotomy in private practice.

Dr. W. E. Casselberry said he was in constant attendance on one of the cases which terminated unfavorably, but the effect from the operation was such as to convince him of its utility in many cases. In this case the former physicians in attendance had thought the patient had recovered from diphtheria, but the membrane later invaded the trachea. The young child was *in extremis mortis* and it was decided tracheotomy would be of no avail, and it was not thought intubation would be much better, but in order to give the child a chance it was done. The child lived twenty-four hours, and its last hours were comparatively comfortable. In this case there was considerable difficulty in the introduction of the tube, and it was a lesson to him that practice in introducing the tube on the cadaver might obviate many difficulties in introducing it on the living subject. In the case of this young child the tube attached to the instrument for introducing it made too short an angle to be easily introduced. The idea suggested itself to have a joint in the introducing instrument so as to be able to easily pass the curve of the pharynx. The tube caused no cough or difficulty in swallowing, and was easily withdrawn. A German physician lately states that in 111 cases of tracheotomy under his control, 63 recovered, and an American physician notes 20 cases, of which 9 recovered. It seems from these statistics that tracheotomy is not to be discarded, but we nevertheless will find a large field for intubation of the larynx. Intubation will be preferable in young children not apt to recover from tracheotomy, in diphtheritic cases, and in cases when the friends object to tracheotomy.

Dr. R. G. Bogue said: I have happened to have something to do with tracheotomy. While there are a great many inconveniences attending the operation and the care of the patients, subsequently, there certainly has been a good deal to commend in its performance in many cases. The number of recoveries after tracheotomy are not few. The gentleman preceding me

referred to statistics showing a larger percentage of recoveries than I had happened to know. But those who have operated a goodly number of times have good reason, from its success, to resort to it in many cases. Intubation is a simple operation compared with tracheotomy, and will recommend itself in many ways, and if it proves to be of equal success in saving life, it should be used in preference to tracheotomy. Many reasons arise why it should be used. It is not a formidable operation: parents' consent to it can be easily obtained, and the relief obtained by intubation seems as great as in tracheotomy. After each tracheotomy there is a period of rest and quiet and apparent promise of success, for a period of twenty-four to thirty-six hours, then an extension of the disease into the deeper air passages, or some complication destroys the life of the patient. The benefit of intubation with only this alleviation is apparent. It is to be hoped after a more extended trial it will prove to be of as much, if not more, service than tracheotomy, and it will commend itself to the profession.

Dr. G. C. Paoli said Diffenbach, of Berlin, was the first to use intubation in diphtheria and croup, and a Parisian physician tried it at the time, each without the knowledge of the other's experiments. Diffenbach used an india-rubber tube, but he as well as the Parisian physician abandoned intubation. This is a different method, it is true, but it can never be recommended until we have statistics from those having great experience, in hospitals especially, to prove it preferable to tracheotomy.

Dr. D. W. Graham commended the report as being an effort in the right direction. It shows that intubation has some merit, as a means of treating obstruction of the larynx, and that it is destined to become at least a partial substitute for tracheotomy in diphtheritic croup. From a theoretical standpoint it would seem that there would be some liability of these tubes causing œdema of the larynx, if retained in place any length of time, on account of the mechanical pressure on the veins of the mucous membrane. Future observation will show whether they are entirely harmless. However, there does not appear to have been any trouble in this respect in the cases reported.

If this method should become established and recognized, as

it now promises, it would and ought to be counted as a new procedure, notwithstanding what Dr. Paoli has said about the efforts of the older surgeons to put the same idea into practice, for whatever has been attempted heretofore in this direction has proved fruitless.

Dr. Waxham, in closing the discussion, in answer to various questions, said the longest time the tube was worn continuously was six days. Dr. O'Dwyer reports two cases, terminating favorably, in which the tubes had been worn ten days. He never found any œdema of the larynx caused by the wearing of the tube. In very young children it is necessary to remove and cleanse the tube. Older children, if not exhausted by disease, will expectorate freely. The previous attempts at intubation in France were not successful, but they were not according to the methods now employed. Trousseau discouraged intubation, and thus French physicians were influenced against it. The tubes must be thin, but their weight is unimportant. He had never found it necessary to use cocaine in introducing the tube, as this operation is generally easily and quickly done.

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## PERISCOPE AND ABSTRACT.

### SALICYLIC ACID IN RHEUMATISM.

Dr. P. W. Latham, the Downing Professor of Medicine at Cambridge, in an article entitled "Why does Salicylic Acid Cure Rheumatism," lays down seven rules for its successful administration:

*First*, The true salicylic acid obtained from the vegetable kingdom must alone be employed. If you have to give large doses, avoid giving the artificial product obtained from carbolic acid, however much it may have been dialysed and purified. An impure acid will very quickly produce symptoms closely resembling delirium tremens.

*Secondly*, Give the acid without any alkaline base. A very good form is to mix 100 grains with 15 of acacia powder and a little mucilage. Allow the mass to stand and harden, and then divide into 30 pills.

*Thirdly*, Place the patient fully under the influence of the drug—that is, let him have sufficient to produce cerebral disturbance—*i. e.*, buzzing in the ears or headache, or slight deafness; with the developement of these symptoms the temperature

and the pain in the joints will begin to decline. To an adult he generally administers three doses of 20 grains (six pills), at intervals of an hour, and if the head remains unaffected, a fourth dose at the end of another hour: and then repeat the 20 grains every four hours until the physiological effect of the remedy shows itself. In the majority of cases, from 80 to 100 grains are enough. In severe cases 140 to 150 may be required. Afterwards about 80 grains a day are sufficient, and as the temperature declines, smaller quantities will develop their physiological effects, 60 or even 50 grains being then sufficient to produce cerebral disturbance. It would appear that as long as the rheumatic poison is circulating in the system, the physiological effect—that is, the effect it produces in the healthy organism—does not show itself: acting as an antidote, the greater the amount of poison, the larger must be the dose of the remedy: but as soon as the formation of the *materies morbi* is stopped, then the excess of the remedy acts as it would in the healthy organism, and its peculiar physiological effects are developed. It is a very striking illustration of the difference between the therapeutical effect of a remedy, and its physiological action.

*Fourthly*, Give the patient from 40 to 80 grains daily for ten days, after all pain and pyrexia have passed away.

*Fifthly*, Let the patient's diet consist entirely of milk and farinaceous food for at least a week after the evening temperature has been normal. On the other hand, if the patient has meat and soup, you may look forward with fair probability to a relapse.

*Sixthly*, Take care to maintain a daily and complete action of the bowels. Calomel is the best purgative, from 2 to 5 grains at night, followed in the morning, if necessary, with a saline draught. This is the most important adjuvant to the action of salicylic acid.

*Seventhly*, Let the patient be enveloped in a light blanket, and with no more bedclothes than are sufficient to keep him from feeling cold. The object of the treatment now is to cool the patient, not, as in former times, to sweat the poison out of him, and the cooler he is kept the sooner will the temperature be lowered.

Dr. Latham has not yet concluded his observations, but so far he considers that though lactic acid has much to do with the symptoms, it is the excessive formation of glycocine and of uric acid in the tissues that develops the symptoms of rheumatic fever, and salicylic acid cures the disease by combining with the antecedents of these bodies, and prevents their formation. When salicylic acid is administered internally it passes off by the urine



as salicyluric acid—that is, it has combined in its passage through the system either with glycocine or its antecedent, for on treating salicyluric acid with fuming hydrochloric acid, it is resolved into salicylic acid and glycocine. Consequently, in the system, by seizing either upon glycocine or its antecedent, salicylic acid takes away an essential constituent of uric acid, and so prevents the formation of this body.—*Lancet*.

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### DIAPHORETIC TREATMENT OF NEPHRITIS.

N. Hess, having made a number of observations on the treatment of nephritic patients by wet packs, hot baths supplemented by wrapping in blankets, and hot-air baths, draws the following conclusions:

1. The least rise of temperature occurs with packs, the greatest with hot baths.

2. While the temperature is found to sink still further twenty minutes after the pack, it remains at the same height for an hour after both the other methods of treatment.

3. After water baths the temperature regains its original height more slowly than after air baths.

4. During the pack the pulse becomes slower; during the water and air baths, on the contrary, it is quickened for an hour afterwards.

5. Under the influence of the pack respiration is moderately quickened; during both water and air baths it is still more quickened, but subsequently returns to its normal rate more rapidly than after the pack.

6. The most powerful sudorific effects are produced by hot baths, the least powerful by packing.

7. Though the baths are more stimulating, packing soothes the action of the nervous system, brings the patients on better, and produces a subjective feeling of improvement afterwards.

*Lancet*.

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### THE BEES AND APOLLO—A MEDICO-PHARMACEUTICAL FABLE.

Once upon a time the busy bees were gathering honey from a flowery field on famed Hymettus. Suddenly one bee was heard to buzz much more loudly than the rest of his companions, who, upon listening, heard that he had found a new process for extracting a superior honey of remarkable medical properties. He had also, at the same time, invented a very ingenious way by which he could with comparative ease make his buzz sound four

times as loud as that of the ordinary bee. By means of these inventions he soon disposed of large quantities of honey at a high price. But one day Apollo, who was experienced in the matter of honey and its medical properties, came that way seeking some good sample for the use of his friend, Diana, who was a little ill. He looked at the new preparation, which was put up in soft capsules and called "honeyine," and at another kind which was put up in chocolate tablets and called "honeyidea." He also listened to the new buzz. "I think," he said finally, "that the buzz is much more wonderful and effective than the honey: I will take it to Diana, who is fond of buzzing."

Some days latter Æsop, on hearing this story, remarked that the moral which he should add was, that the art of advertising a new medical preparation is of more importance than the art of making it.—*Boston Med. and Surg. Journal.*

## SHOCK AND ITS TREATMENT.

In a critical study of shock intended to elucidate its pathological relations, Groninger, of Berlin, defines shock as an exhaustion of the medulla oblongata and the spinal cord produced by violent excitation. This definition is no doubt perfectly proper, though it strikes us as if the term "exhaustion" is not sufficiently clear for defining purposes.

He recognizes the following varieties:

1. The lowest grade of shock, which causes no appreciable effects.
2. A middle grade, which weakens sensation.
3. A high grade, which extinguishes qualitative sensation.
4. A highest grade which eradicates both passing and permanent sensations of every kind.

His views of the treatment are noteworthy:

Energetic counter-irritations of the skin are to be excluded as useless and even dangerous.

Abstraction of blood is contraindicated.

Transfusion of blood can only be thought of in cases of great loss of blood.

Opium and chloroform are of no value whatever in shock, while digitalis is worthy of further study.

Alcoholic stimulants and subcutaneous excitation are useful. Horizontal posture, application of warmth, perfect rest, and subcutaneous injection of strychnine are the most recommendable factors of treatment.—*Therapeutic Gazette.*

## THE ECLECTIC JOURNALS.

There come two or three Eclectic journals to our office. We read them because we are searching in every direction for something to interest and benefit our readers, and, peradventure, we might catch a thought from an Eclectic journal; and yet, if, under like circumstances, we were to exercise the same liberality in the ordinary relations of society, our conduct would be regarded as incompatible with self-respect. It would not be expected of a gentleman to receive visitors into his house who took occasion at every visit to ridicule his sentiments and to heap upon him offensive and opprobrious epithets. But this is just what every Eclectic exchange does for us that we receive. *Scudder's Journal*, which is prominent among that class, is especially given to that sort of exercise toward what he styles *the Regulars*. In his August issue he devotes several pages to this gratifying amusement, bringing in this journal for a share of his courtesies. We often wonder what this class of journals would do if deprived of the privilege of abusing the Regulars; and yet it must be hard to keep it up, as the Regulars rarely notice or respond to their assaults. Usually the most pugnacious animal will lose his ferocity when no opposition is offered to his attacks; but these fellows never tire, from which we infer that the matter of these assaults is not only luxurious to the editors, but ever fresh and attractive to their readers. When they have nothing else to interest their subscribers they can always get up something in this line to fill up with, and feel safe in so doing. This is in keeping with the advice of an old political editor to his son, whom he was instructing in the business of journalism, when he said, "Well, son, when you get out of soap, and can find nothing to say, the best thing to do is to abuse the opposite party."—*Southern Med. Record*.

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### COUNTER-IRRITATION IN THE BRONCHITIS OF CHILDREN.

The value of counter-irritations in bronchitis and severe colds is very great, but it only seems necessary here to call attention to an old, but almost forgotten remedy, the oil of amber, as being especially valuable in the treatment of bronchitis of young children, associated as it so often is with marked nervous disturbance and a tendency to collapse. The oil diluted with from one to three parts of sweet oil applied to the chest as a sort of stupe (upon saturated flannel) sometimes acts very happily in allaying nervousness as well as internal congestion.—*H. C. Wood in the Therapeutic Gazette*.

## THE CURABILITY OF CONSUMPTION.

In an article on pulmonary phthisis in the *Medical Record*, of the 21d ult., Dr. J. Milner Fothergill, of London, makes the somewhat startling assertion, based on an experience of ten years in a chest-hospital, that the disease is far from being necessarily fatal. Under fairly favorable circumstances, he holds, a rally may be made in the large bulk of cases, which may lead to recovery. This is glad tidings, and a detail of the means through which this consummation may be reached, will be eagerly read. It is customary in acquainting the patient of the fact that he has consumption, to do so in a tone and manner calculated to shut out from him the faintest ray of hope. Treatment, moreover, is usually undertaken with a view to euthanasia, rather than with a hope to snatch the brand from the burning. If, therefore, Dr. Fothergill has put it in our power to tell the consumptive that the odds are in favor of his outliving his disease, he will prove to have been one of the greatest of the benefactors of this and succeeding ages. He does not propose anything particularly new in the way of treatment, nor does he vaunt any specific. His common sense application of means already familiar will, however, commend themselves to the attention of the profession.

The line of attack advised in incipient cases is to improve the general condition, in which improvement the new growth have its share. To check the body expenditure and to increase the body income are our aims. All out-goings must be stopped. This is the first step. If a woman, attend to any leucorrhœa at once. Many a good line of attack has failed, many a woman sunk into her grave who might have been rescued, if only that out-going had been attended to. If the catamenial loss be heavy, put an arresting finger upon it by some ergot, sulphuric acid, and sulphate of magnesia, commencing with this two days before the appearance of the flux, and continuing it during the flow, reverting to the usual treatment on its completion. Then, is there diarrhœa? If so, attend to it. Milk and farinaceous matters are indicated (no meat-broths, no beef-tea—"giving the patient a stone when he asks for bread"—unless some farina be added). Then for medicine some astringent preparation of iron may be given in the day, and a pill of sulphate of copper (gr.  $\frac{1}{4}$   $\frac{1}{2}$ ) with opium (gr.  $\frac{1}{4}$   $\frac{1}{2}$ ) at bed-time. If there be both diarrhœa and night-sweats this pill will often "kill two birds with one stone."

If there be night-sweats, arrest them at once, or as soon as may be. Sweat is an excretion, and is highly charged with blood-salts. Consequently, profuse sweats are most exhausting. Check them, and the appetite returns, and between the two the



patient does well. Prof. Sidney Ringer, F.R.S., has laid the phthysical world under a deep debt of gratitude by pointing out the potency of belladonna in the matter of hydrosis. The best preparation is atropine, not only because it is tasteless, but because we know exactly what we are doing when using it. But to secure its good effects it must be pushed. Its effects upon the pupil is nothing. Indeed, in a very extensive use of belladonna the pupil has rarely been affected. (The effect upon the pupil is a bug-bear which ought to be buried). Dry throat and dim eye-sight are discomforts, but unless severe they need not disturb the treatment. There is a wide gulf between these and any real danger. The very lowest dose is  $\frac{1}{15}$  of a grain. If this does not achieve the desired end, then  $\frac{1}{50}$ . If that is insufficient, then  $\frac{1}{25}$ . If that fails—which it rarely does—one must begin to look seriously at the case. When this dose is reached, and yet the sweats continue, Dr. F. adopts the plan of an old New York quack, of which Lewis Sayre told him, viz., to sponge the paper over with hot vinegar ( $\frac{1}{2}$  pint) with a teaspoonful of cayenne in it. This is not at all disagreeable, and is effective. If the combined measures fail, the patient's case is hopeless, but his physician's conscience is clear.

Perhaps the patient's rest is broken by cough. Dr. F. recommends the following combination in such cases: Morphine, (gr.  $\frac{1}{3}$ ), atropine (gr.  $\frac{1}{30}$ ), with pil. galban co. or "pil. al. et myrrh.," as the case may require. This is a pill which has done him yeoman service in his warfare with phthisis. It has found its way into the Brompton Hospital, and more recently into Squire's *Companion to the Pharmacopæia*. It will, he thinks, find its way before long into every consumption hospital in the world. This action of carbonic acid upon the sweat-glands has led Dr. Lauder Brunton to advocate strychnine (a potent stimulant to the respiratory centre) in the night-sweats of phthisis. No doubt it is useful. Dr. F.'s practice is to give it in the day-medicine. His favorite mixture at the hospital consists of liquor strychnine (4 minims), acid. phosph. dil. (15 minims), tincture capsici (4 minims), in infus. gent. (3 dr.), *ter in die*. This forms a capital tonic. Some quinine or sulphate of magnesia (or soda) may be added as required.

One of the rules which have formed themselves in his mind is to give acids when the tongue is clean or coated. When the tongue is bare, raw, or irritable, then alkalines are indicated as am. carb. (g. 2 to 5), tinct. nuc. vom. (10 minims) inf. gent. (1 ounce), *ter in die*.

On such a line of treatment the patient usually improves. The night-sweats cease, the appetite returns, the cachectic look departs, and the patient feels much better. The improvement is

maintained, and soon iron and arsenic can be added to the strychnine, and cod-liver oil to the dietary (but cod-liver oil is not the best form of fat, nor yet the most palatable, though it is the most digestible. Some forms of fat in an emulsionized state are now on the market which possess many advantages over cod-liver oil). Iron is a good hæmatinic.

Arsenic is an alterative and a tonic greatly believed in by many good observers in lung-consolidation. If the patient can be induced to take fat in any form the healthy tissues can be built up. Very commonly the affected area is found to shrink, and air to pass into it. In a few months, in many cases, it is scarcely possible to detect any change in the lung. The threatened danger has passed away!

All along in the treatment advocated the matter of improving the condition has never been lost sight of for a moment. If the patient can get away to a dry soil and a bracing locality, all the better for him or her.

Another common patient is the person who has chronic phthisis with cavities. Such patient is always spare and badly nourished at the best; and when any intercurrent ailment still further lowers the general condition the lung trouble is aggravated. (And one matter has forced itself upon his attention, viz., that wherever there is old lung-consolidation any disturbance in the liver sets up irritation in this consolidated patch with resultant cough. And this cough, which is intractable to ordinary cough-medicines, is relieved by acting upon the liver.) The appetite has fallen off and the nutrition is impaired; and then the special danger in phthisis is set up. Very often the tongue is raw, or beefsteaky, or patchy. Here attention to the *primæ viæ* (as our grandfathers phrased it), is imperative. The patient must be sent to bed, to reduce the body expenditure to the minimum. The medicine must be bismuth, with alkalies; and the food, milk with malt extract, or a malt preparation with Mellin's food, in small quantities at a time, oft-repeated. No solid particle in the stomach to vex and irritate the sensitive (because ill-fed) mucous membrane. Even an alkali—like carbonate of magnesia—may be required to neutralize acidity and prevent too firm curdling of the milk; as much as will lay on a sixpence to the half-pint of milk is usually sufficient. Having got the assimilating processes into good working order, the tonic may be given. "The more haste the less speed" is especially true of the treatment of phthisis; and the desire to push on with tonics and good food sadly too often defeats its own end. Sometimes a masterly inactivity is the wisest practice. A clear head and a firm will are often required to curb the desire of the patient (and still more the patient's friends) to be getting on. Back-

cast after back-cast teach a painful lesson to the medical man, and involve the patient in acute danger. If the pressure put on a young medical attendant is becoming more than he can bear, let him call in an older head to help.

The chief thing to avoid is morphia tinctures for the cough. An opiate to procure sleep may be essential and unavoidable; but sedatives in the day are dangerous. They give relief from the cough but too commonly they give permanent relief by death. Opium lays its palsying hand upon the assimilative organs, and destroys the appetite. Its evil effects seem most distinctly felt by the liver. When an opiate is indicated at night it should be combined with ipecac to antagonize its effect upon the liver, and with aloes and myrrh pill to correct its action upon the bowels. Opium strikes directly at the assimilation which is the cardinal matter in the treatment of phthisis. The patient most certain to die, the case least amenable to any treatment, is that one whose wasting progresses steadily, and where the lungs are only affected quite late on—indeed, a brief while before the final change sets in.

As to other means of allaying the cough than opiates, inhalations of steam are often serviceable. Friar's balsam, iodine, carbolic acid, terepene, eucalyptus, all are good as additions to steam. Where there is a cavity with ragged walls smelling offensively, a respirator with cotton wool charged with carbolic acid is indicated.

Then, as to the other means of feeding the patient, there are inunctions of oil, often of service, especially with young subjects. Nutritious enemata have only lately suggested themselves; but in one case of a medical man steadily wasting, an enema of cod-liver oil (emulsioned by a drop of bile) and milk in equal quantities is being tried. Such enema night and morning, while in the recumbent posture, would be readily retained. When the temperature mounts up, and especially when the skin is also moist (the usual state in hectic fever connected with phthisis), Dr. F.'s plan is to give quinine (gr. 2 to 5) with tincture of digitalis (10 to 15 minims) and dilute phosphoric acid (15 minims.) thrice daily. The effect is very satisfactory usually. Where a severe raking cough is present, shaking the poor sufferer terribly, it may be necessary to give opiates; but, in the author's experience, such cough is very rarely found with pulmonary phthisis.

The treatment of hæmoptysis is quiet; no movement, no talking. When it arises from the bursting of an aneurismal sac in a cavity, or from an ulcerating process eating into a blood-vessel and opening a communication between the vessel and an open air-tube, syncope alone is likely to arrest it. In congestion

of the lung it is often an excellent form of local bleeding. Men of old bled for its relief: now free purgation with mineral salts is in vogue. For small recurrent hæmoptyses the best treatment is to keep the bowels open. Ice, ergot, and dilute sulphuric acid may also be tried; probably they will do no harm. It is a bad plan to feed up a case of recurrent hemorrhage: it only fills the vessels rapidly, to end in more bleeding.

Finally, the management of phthisis pulmonalis, whether the less grave or the more serious conditions, is a good test of the knowledge, skill and tact of the practitioner, who must, like a competent soldier, be able alike to plan a campaign or execute a sudden change of front in an emergency. That is, he must be able to lay down a persisting plan of treatment, and promptly change his plan to meet some intercurrent condition, as hæmoptysis or acute gastric disturbance.—*Med. Age.*

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### PROLAPSE OF THE RECTUM.

In the *Polyclinic* for June 16, 1885, appears an excellent clinical lecture by Prof. C. B. Nancrede, of Philadelphia, relating to this subject, from which we make the following abstract: After speaking of this condition of the bowel in young children, and some of the causes for its concurrence, he went on to relate the details of his general treatment in such cases. He called attention to the paramount importance of not allowing the child to strain at stool, nor even to sit any length of time on such occasions. The motions should only be passed lying on the side, at the edge of the bed, or even standing, and, whichever position was employed, traction should be firmly made upon one buttock, so as to tighten the anal orifice. The credit of this valuable aid to treatment he gave to Dr. H. Macormac, of Ireland, who first showed its worth to the profession in 1843. The lecturer advised the invariable use of plain enema of cold water before each rectal action, with a thorough bathing of the parts with cold water afterward. An unirritating astringent injection should be thrown up into the rectum, such as a decoction of white oak bark, or a solution of sulphate or sub-sulphate of iron. He went on further to speak of the various mechanical appliances which have been suggested to retain the prolapsed bowel in place, after returning it to the rectum. A pad of oakum or tow, or better than either, a piece of soft sponge, should be placed over the anus, and the buttocks firmly pressed together and retained in position by a broad transverse strip of adhesive plaster. This pad, however, should be used only in those cases where the skin is not irritated: and when, despite the careful bathing of the



parts in alcohol, it does become inflamed, some one of the many anal trusses must be resorted to, if the case is a very old or desperate one, otherwise an operation for the radical cure of the affection should be performed.

In answer to the question as to which cases had best be operated upon, he could only say, those in which palliative measures are either inapplicable or inoperative. As to the method of operating, he called attention to the study of the pathology of the affection, for a proper understanding of the subject. When from any cause the mucous coat of the rectum has slipped away from the muscular coat, on account of the elongation and laxness of the sub-mucous coat, this condition (prolapsus) is of course established. Now, naturally enough, anything which will set up a certain degree of plastic inflammation in that sub-mucous coat will glue together, as it were, the mucous and sub-mucous coats, thus producing a cure—always provided the sphincter ani muscle is not in a condition of atony or fatty atrophy.

The lecturer then referred to the different means of producing the necessary plastic inflammation, and clinically described the operation he preferred as the safest and most expeditious. After etherizing the patient and elevating the hips upon a pillow, he reduces the prolapsed part, and introduces a large-sized Sims' speculum. Then with the thermo-cautery, at a dull red heat, he draws three or four lines, commencing about two inches within the anus, and bringing them down to the delicate muco-cutaneous margin. An opium suppository, and a pad and bandage, complete the operation. The lines mentioned may be drawn with a pointed glass rod dipped in nitric acid, or the actual cautery, or the galvano-cautery may be employed, but in his opinion neither equalled the thermo-cautery for simplicity and safety.

He called attention to the importance of the after treatment. The patient must retain the recumbent position for at least a week, all stools being passed in the lateral position, or into a bed-pan; and even after leaving the bed the bowels had best be moved in one of these ways for a week or even ten days longer, all symptoms of costiveness being relieved by enemata rather than purgatives. Care should be taken for months afterward to keep the buttocks as closely together as possible during an operation of the bowels.

Should the first operation fail to produce a radical cure, a second may be performed, and new lines can be drawn between the old ones, or a series of scattered points may be touched with the cautery, great care being exercised, however, not to destroy too much tissue lest a stricture result.

## TREATMENT OF HARE-LIP.

The *Maryland Medical Journal*, July 18, 1885, contains the conclusion of a valuable article on "Surgical Treatment of Infants," by Dr. De Forest Willard, of Philadelphia, from which we take the following on the hackneyed subject of hare-lip. Notwithstanding the fact that this affection has been so thoroughly written about in past years, there is much that is practical and original in Dr. Willard's remarks upon the treatment.

He thinks, and very truly, that the proper relief of the affection is not only a matter of surgical skill, but of surgico-artistic skill, the region being of so much importance in a cosmetic point of view. After referring to the wide diversity of opinion expressed by surgeons as to the best time of infantile life when the operation should be performed, he says his rule is to relieve the deformity within three or four days if it interferes with the proper nursing of the child, although practically it often happens that by the end of the operation the milk has left the mother's breast, unless natural means have been taken to keep up the flow. He prefers to wait, if possible, about three months, until a full, vigorous activity of growth and cell section is at work, and before dentition has commenced. Besides this reason, the child at that age cannot use its hands as freely as at a later period, thus avoiding some risk of injury to the patient.

When operating upon fractious children, he no longer uses pins, but uses small catgut sutures for the mucous surfaces, which if properly inserted and tied in three knots, will remain in position until union occurs. For the skin edges he uses carbolized interrupted silk sutures, his reason for stitching the two surfaces separately being that there is less linear depression of the cicatrix, and less constriction of tissues is thereby exercised, than by pins and figure of eight, while if each set penetrate half way through the lip antero-posteriorly, the sphincter is thoroughly controlled. One of the stitches should pierce the coronary arteries. He prevents any pouching of the flaps or separation of the deeper parts by oozing, by means of drainage by horse-hairs left in for a few hours. He is not satisfied to simply apply transverse strips of plaster over the wound, but prevents any strain upon its lips by placing another strip on either side, beginning on the neck in front of the sterno-mastoid muscle near the horn of the hyoid bone, thence running just above the angle of the mouth across the opposite malar bone to the front of the ear. If these are all placed in position while the cheeks are held well together, it will be found, on releasing the grasp, that the minimum of tension is exerted upon the stitches. An excellent plan also is to have the nurse regulate muscular action of the face

during the first few days after operation, by pressure upon the cheeks whenever the child cries or eats.

As it is only by securing union by first intention that a narrow cicatrix can be hoped for, Dr. Willard does not allow the child to suck, as is the practice of some surgeons, but much prefers spoon feeding as producing less disturbance of the parts, and for the same reason does not hesitate to use anodynes to control pain and hold the little one in as quiescent a state as possible, of course keeping the patient in as perfect a physical condition as can be managed.

He does not use the simple inverted V-incision, but commencing the cut at the apex of the cleft, stops just before reaching the border of the lip, thus leaving a base of supply to nourish the flap which remains on either side—in this avoiding the marginal depression so commonly seen where the first named method is adopted. The two flaps, when the parts are brought together, project downward and form a fleshy prominence, but if the stitching is nicely done, subsequent absorption will, in a year's time, give only a slight projection. Even should it remain too large, a simple scissors cut will remove any deformity, while the ugly notch sometimes left after the V-incision can never be corrected.—*Virginia Medical Monthly*.

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## PRURITUS PUDENDI, DUE TO VASCULAR TUMOR OF THE URETHRA.

Mrs. W., æt. 42, Feb., 1884. She was complaining of almost intolerable itching and burning pain in the "fore-parts," and had been doing so for more than two years. The itching, which had originally been confined to the vulva, had gradually extended back to the anus, down the inside of the thighs; across the groins, and was beginning to affect the lower part of the abdominal wall. The itching was not constant, but used to come on at irregular intervals, in paroxysms lasting from a few minutes to several hours. One of these paroxysms was already induced by warmth in bed, by exertion, and by marital intercourse; and the attacks were always worse just before, during, and immediately after menstruation, and in warm weather. During the paroxysms, the condition of the patient was almost unbearable. It was impossible to resist itching and rubbing the parts whilst the itching continued, but this only served to aggravate the discomfort, for when the itching ceased, a tingling, burning sensation remained in the parts which had been most irritated by scratching. The patient said she had lost a great deal of flesh; was quite unable to sleep at night; suffered from great depres-



sion of spirits and irritability of temper; and latterly, so much nervous disturbance had been produced, as to give her friends grave cause for fearing that her mind would give way. Having eliminated the usual causes of pruritus, I fancied I could detect an urinous odor about the patient, and, on being questioned, she acknowledged being troubled with frequent calls to micturate, scalding pain during the act, and dribbling away of urine if the first desire to empty the bladder were not immediately gratified. Upon examination, I discovered a small, sessile, vascular growth, about the size of a hazel-nut, surrounding the lower segment of the meatus urinarius, and extending along the floor of the urethra for a short distance. The little tumor was exceedingly sensitive to the touch, and bled freely on the slightest manipulation. There was considerable thickening of the whole urethra, which could be easily traced as a firm cord, tender on pressure, running beneath the symphysis pubis. The long standing congestion of the whole urethra, often concomitant with vascular caruncle of the urethra, had evidently been followed here, as elsewhere, by hypertrophy of the cellular tissue of the urethra. There was a free ichorous discharge from the excrescence, and there could be little doubt that this acrid matter, mingled with urine, was the cause of the pruritus. The labia were hypertrophied, dark colored and rigid, evidently the objective consequences of frequent intense scratching and rubbing. They were considerably excoriated near their mucous surfaces, and more externally were covered with eczematous patches, which extended half way up the fold of the groin on either side. The eczema did not appear until some time after the itching began to be complained of, and was evidently the result of scratching.

*Treatment.*—The patient having been anæsthetized, the thighs were flexed and the knees separated as widely as possible. The labia being now separated, I dissected out that part of the excrescence which affected the urethral lips, cutting well beyond the base of the growth. I was then enabled to dilate the urethra sufficiently, with a pair of dressing forceps, to remove that portion of the growth which encroached on the urethral canal. The raw surfaces were then lightly touched with Paquelin's cautery, partly with the object of arresting the hemorrhage, which was rather copious, and partly with the object of obviating the return of the growth. The tissues of the posterior urethral wall were so vascular and hypertrophied that I deemed it necessary to destroy the deep tissues below, so as to cut off the supply of blood to the surface of the urethra. This was done by passing the incandescent needle deeply beneath and parallel with the urethra, but without interfering with its mucous membrane. A soft catheter was then passed into the bladder, and was left in for a



week. After this period it was passed at intervals, for a short time, to obviate undue contraction of the urethra. A liniment of chloroform and almond oil (40 minims ad 1 ounce) was ordered to allay the sense of itching and burning. This it did effectually. After the removal of the catheter, there was incontinence of urine for a few days; but the power of retention gradually returned, and was complete three weeks after operation. Shortly after this time, too, the pruritus and eczema had completely disappeared. Six months afterwards there were no signs of return of the growth, and the itching had never been complained of. I have seen three other cases of a similar nature: a girl of twelve, a young woman of eighteen, and an elderly lady. In each case a similar plan of treatment was adopted, and in each case the result was equally satisfactory. *Australasian Med. Gazette.*

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### CITRIC ACID IN THE EXTIRPATION OF MALIGNANT TUMORS.

C. M. Finn, M. D., of San Diego, Cal., writes as follows in the *Journal of American Medical Association*:

Prior to the revelations of the microscope morbid growths, with few exceptions, were looked upon as local manifestations of some blood dyscrasia. They were known to be environed by a zone of infiltration or degeneration, or varying area, and the question of recurrence after an operation was supposed to depend largely upon the extent of the incisions. The desire, however, to preserve symmetry, especially if about the face, and to hasten cicatrization, frequently induced the surgeon to circumscribe his operative procedures, relying subsequently upon antiseptic applications to sterilize flaps and adjacent tissues. Unfortunately, it was seldom possible to thus reach the extreme boundaries of the disease, hidden as they were to sight, and the *materies morbi*, with lymphatics and blood-vessels as avenues (?), quickly invaded other tissues and viscera; or the increased supply of nutrient material, in the absence of the central mass, soon precipitated a recurrence at the original site. This process was all the more rapid after attempted extirpation by pastes and caustic lotions. Consequently the impression prevailed that surgical interference merely postponed the fatal denouement.

Cellular pathology, however, has modified some of these theories, while confirming others. It has taught us, I think, that tumors, excepting, perhaps, the essentially cancerous ones, are for the most part of local origin, whether homologous or heterologous as to the tissue from which they arise; that the drier ones are seldom recurrent, and that when metastasis and recurrence

take place, it is through the medium of morbid juices, which invade connective and other loose tissues, and set up foci of disease in other portions of the economy. These later investigations, in my opinion, should encourage the surgeon to attempt at least the radical extirpation of all kinds of tumors, though custom and classification may have placed some of them among the *noli me tangere* class.

While yet a student, some twenty years ago, it was my privilege to assist in the removal of a great many epitheliomatous and other abnormal growths, and the rapidity with which some of them recurred impressed me most forcibly at the time. In many instances plastic operations were successfully undertaken to conceal deformity and promote cicatrization, but at a later period these only added fuel to the flames. In later years, having adopted the non-systemic therapy, and recalling the well known antagonism of citric acid to diseased tissue, while comparatively innocuous to healthy cells, I devised a method for the extirpation of doubtful and malignant tumors which I shall be glad to see thoroughly tested. It consists, as will be noted, in an attempt to segregate the degenerated zone before using the scalpel.

The notes of a few cases, of dates sufficiently remote to justify conclusion, will best illustrate the process:

Col. H. T. C., aged 48, of undoubtedly cancerous antecedent, his grandfather and father having succumbed to malignant disease of the face, had been appealing to thirty-third triturations for the removal of a suspicious tumor situated upon the left ala of the nose. Notwithstanding the *attenuations*, the disease had rapidly extended down the side of the nose until a large segment of it rested upon the cheek. Its track, fully an inch in length, and more than six lines in width, resembled the cicatrix of lupus exedens. When first examined by the writer the tumor, now larger than a filbert, had a sessile attachment, an encrusted summit, and, in addition to an indurated margin, was evidently exceedingly vascular. The elderly gentlemen remembering the fate of his ancestors, whose lives had scarcely been prolonged by the frequent operations to which they had been subjected, was naturally very despondent, and while decidedly opposed to the employment of caustics, he was correspondingly incredulous as to any permanent relief to be obtained from the knife.

At the outset my armamentarium included an old hypodermic syringe and a saturated solution of citric acid. The needle was introduced deeply into the base of the growth, and about half a drachm of the solution injected. The entire mass became blanched at first, following which a few drops of the acid, mingled with blood, escaped at the surface. Beyond an insignificant tingling, the suffering was so slight that he voluntarily

returned on the following day for a repetition of the operation. At intervals of two and five days the process was repeated, until a large zone had been thoroughly saturated with the solution. The size of the tumor gradually diminished until a nodule as large as a small pea alone remained. After a lapse of about three weeks this nucleus was raised upon a tenaculum and excised. The hæmorrhage, as had been anticipated, was quite profuse, but yielded readily to styptics and compression. During the entire period of manipulation, the local irritation seldom required restraining lotions. More than six years have already passed without any evidence of recurrence, and the colonel feels that he has made a narrow escape.

A second case occurred in the person of a middle-aged matron, who also gave a history of a cancerous diathesis in her family. The tumor was situated between the eyes, and was slowly encroaching upon each of them. Immediate excision could not have been undertaken without leaving a most unsightly deformity. Subcutaneous injections of a similar kind were therefore used, the needle point being directed at times toward the center of the mass, and, again, outwardly, in various directions. A diminution of the induration was soon perceptible to the touch at the periphery of the zone, and continued until an elliptical incision, having a horizontal diameter of not more than twelve lines, included the entire growth. Three years have now elapsed without a return of the disease.

Still another illustration of the vagaries of the cancer and the possibilities of this treatment may not be out of place here. A lady, of perhaps 40 years, stated that about two years previous to our interview, and without any assignable cause, a hard lump made its appearance, a little to the right of and below the right breast. It had been twice operated upon in a distant city, without removing the indurated or mammary and axillary glands. After a brief interval of repose it had again come to the surface, and was now manifesting increased virulence. A fungoid mass, as large as the top of a tea-cup, occupied the original site, and was so painful that large doses of opiates only procured temporary relief. It was evident that the system was so saturated with the cancerous juices as to preclude further surgical interference. An operation promising even a temporary respite would have involved excision of the breast and axillary glands and an area of integument at least five inches in diameter. As in the other cases, citric acid was injected into the tumor and adjacent tissues, with the results that pain was mitigated, hæmorrhage somewhat restrained, besides other evidences of improvement. It was, of course, impossible to stay the progress of the malady by any other course of treatment.

## MOUNTAIN FEVER.

The fall of 1880 witnessed the beginning of the great rush of immigration to Dakota. In September of that year I located at Pierre, on the Missouri River, and the prospective terminus of the Northwestern Railway. The latter, being built at the rate of two miles a day, was employing several hundred laborers. Of the village itself, the population at this time did not exceed five hundred. When I arrived on the ground, September 5th, I was the only physician (though others soon followed), and I found myself confronted by a form of fever entirely new to me. During the months of September and October I treated as my notes show, seventy-three cases of the fever, forty-eight of which were in the camps of the railway laborers, and the balance in the families of the village, ranchmen and teamsters on the Black Hills' freight lines. That my first cases should puzzle me I think you will readily see, when I inform you that they were typhoid fever with the abdominal symptoms left out; and, briefly, that is my definition of mountain fever. It is typhoid fever with the principal anatomical lesion of that disease lacking, viz., inflammation of the glands of Peyer. We have the typhoid skin (except the characteristic eruption), tongue, temperature and pulse, the latter ranging from 100 to 120 or even higher; but as it increases in frequency its force declines. It is a pulse of debility. The same ataxic symptoms, cases varying in this particular just as they do in typhoid; some characterized by merely a mental hebetude, others with low muttering, delirium, subsultus tendinum, carphologia, stupor, and in a few cases active delirium. Bronchial complications exist in about the same ratio as in typhoid, and due to the same cause—hypostatic congestion. In most of the cases the skin remained dry throughout; exceptionally there were cases with free perspiration. Usually the skin was dry and dusky, the secretions diminished: urine lessened in quantity, with, of course, increased specific gravity, and in a few cases slightly albuminous, but not sufficiently so to constitute a pathological element in the disease.

I desire to call attention to two important features of this disease proving conclusively to my mind that it is a new fever, at least so far as our medical literature is concerned, and first, the fact of the bowels not being implicated proves that it is not typhoid, which it so nearly resembles. In fact the belly remains flat throughout its whole course, and, from the fact that anorexia prevails, and forced feeding of the usual concentrated diet of the sick-room is all that the patients take, the belly usually becomes retracted, in some cases really hugging the spinal column, owing to the emptiness of the intestines. There is no diarrhœa, the



bowels usually requiring a mild laxative; and the excreta is normal in character. Again, it is a continued fever, running from twenty-one days in mild cases to fifty-six in extreme ones. From an observation of nearly one hundred and fifty cases that I treated during my two and one-half years' residence in Dakota, and a few cases seen at this place last autumn, I should place the average duration of the fever at about twenty-eight days, that is, counting from the time the patient seeks medical advice, or takes to the bed, until convalescence is established. The convalescence is very tedious, moreso than in typhoid even. In fact, it is usually many months before the subject regains his usual vigor. It is not remittent, except in the sense that all fevers are so. We have the morning fall and evening rise, the temperature ranging about 101 to 102 degrees F., morning; 103 to 104 degrees F., evening; exceptionally it may reach 105 degrees F. I believe I have never seen that figure exceeded, except in a fatal case mentioned hereafter. It is positively not malarial, for the good and sufficient reason that quinine will not abort it nor shorten the attack.

Of symptomatology I have said much; of its pathology I can add nothing. The intrinsic tendency is unquestionably to recovery. The tendency to death is certainly by slow asthenia, and the indications are to support the patient first, last and all the time. Alcoholic stimulants and ailmentation form the basis of treatment. That the disease sometimes proves fatal there is no doubt.

Regarding causation I can say but little. It is an autumnal fever, though I have met with cases at all seasons. It usually begins late in August, though it may come earlier, and it invariably ends with the beginning of winter. No age or race is exempt, but by far the largest number attacked are young men and laboring men. In regard to the probable causation I can only advance one plausible theory, and I give it for what it is worth; and that is the great diurnal variation of temperature that occurs in elevated countries. During that memorable September, 1880, the thermometer ranged in the nineties during mid-day, frequently reaching 100 degrees F. in the shade; and at night water exposed outside of the house would be found frozen in the morning. This, coupled with the fact that by far the larger number attacked were men who worked exposed to the direct rays of the sun, and slept in the same garments they wore during the day.

Regarding the morbid anatomy of this disease, I am sure that here, as in all diseases characterized by long-continued high temperature, parenchymatous degenerations take place in the various organs—the liver, kidneys, spleen, the muscular struc-

ture of the heart, etc. This opinion I had a chance to verify in the case of a young man of twenty-six whom I was called to treat in the second week of the fever. In this case the temperature was very high, 106 degrees F. He was wildly delirious, requiring to be held in the bed, spitting out food and medicine; and died in thirty-six hours after I was called in, and on the twelfth day of the attack. With some difficulty myself and Dr. Henry Frisius succeeded in getting permission to examine the abdominal organs. Briefly, the autopsy revealed a healthy condition of the intestinal canal, but we found fatty degeneration, or what is usually denominated "cloudy swelling" of the liver, spleen and kidneys. The liver and spleen were notably softened and pulpy.

I am firmly of the opinion that "mountain fever" is not a myth in the brains of ignorant western practitioners, but a new and distinct pathological entity, and as such it should take its place in medical literature.—*Kansas City Medical Record*.

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### TREATMENT OF PALMAR GANGLION.

The *Lancet*, June 27, 1885, lays down the following rules for treatment of palmar ganglion, as in accord with the best and most recent views of surgical authorities on the subject. The first point of importance is to attempt the cure of the cases as early as possible. No good can come of delay, which merely leads to greater distension of the cyst, and is especially to be deprecated as endangering the adjoining tendons, which become stretched, and even in some cases severed, by the pressure to which they are subjected. Second, the free evacuation of the cyst and the removal of all the "melon-seed bodies" it contains, whether these be free in its interior or adherent to its walls. For this purpose an incision about an inch and a half long, not a puncture, should be made in the most prominent part of the swelling, above the annular ligament, avoiding, of course, the radial vessels and the tendons, which can be felt through the skin. Pressure should be made in the palm to force out the fluid and as many of the loose bodies as will thus escape. Then a sharp spoon should be introduced, and the whole cavity scraped, to detach any "bodies" which may be still fixed to the synovial membrane. The "spoon" is much the best means of doing this. Some have trusted to injecting a fresh stream of fluid into the cyst, but this will not remove "bodies" which are still firmly adherent to the cyst-wall.

Volkman passes a large drainage-tube through the cyst, and draws it sharply to and fro, and trusts to that to detach any

adherent "bodies;" this is, however, an uncertain method, and if the cyst be old and large, with pouches extending from the main cavity, they escape the friction of the tube altogether. Having thus carefully removed all the contents of the cyst, whether solid or fluid, a solution of chloride of zinc, 40 grains to 1 ounce, should be applied to the whole interior of the sac, the purpose of this being so to modify the nutrition of its lining as to prevent any recurrence of the dropsy. A solution of iodine has been used for the same purpose, and some surgeons may be inclined to use iodoform instead. The most important steps in the treatment are those to be taken to secure healing of the wound without suppuration, at any rate without septic suppuration. As a preparatory step the parts must be thoroughly cleansed before the incision is made, and the operation should be conducted under an antiseptic spray or irrigation, and some efficient antiseptic dressing should be finally applied. A drainage-tube should be introduced into the wound and passed down beneath the anterior annular ligament, and only removed when the discharge through it is reduced to a minimum.

Dr. Weiss shows that if pressure be carefully applied over the palmar part of the cyst, all retention of fluid can be carefully obviated. The hand should be kept fixed on some kind of splint applied to the extensor aspect, until the wound inflicted is healed. As soon as that is accomplished, the fingers should be liberated and the patient be encouraged to move them. The results of this treatment are entirely different from those formerly met with. When the antiseptic precautions are carefully carried out, there is no danger whatever of blood-poisoning or of profuse local suppuration, and the final result is the restoration of a thoroughly useful hand. The tendons are not bound down by cicatricial bands, and after a time it may be impossible to find any trace of the previous mischief beyond a linear scar in the forearm. Weiss considers that the process of cure of the synovial cyst is analogous to that obtained in a hydrocele by injection, or in dropsy of a joint treated by injection of iodine. At present no case of a recurrence of the ganglion after a septic incision and drainage has been reported.

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In Russia it is proposed to adopt a code of medical ethics, some of whose features are the following: "A practitioner who gives his adherence to any system of medicine unrecognized by science must be considered as having forfeited his rights of professional fellowship. It is also forbidden to write, publish or distribute pamphlets giving the symptoms and treatment of diseases. Nor can the doctor give testimonials as to the value of remedies and mineral waters, etc."

## THE TREATMENT OF SCIATICA.

The *Boston Med. and Surg. Jour.*, in an editorial article, directs attention to Debove's new method of revulsion by congelation. To this end he has had recourse to chloride of methyl, which is readily obtainable in commerce, and with which one may produce a speedy refrigeration. Debove says: "I practice with this agent, using for the purpose a siphon bottle furnished with suitable stop-cock and beak, pulverizations along the diseased nerve, directing the spray especially upon the *points douloureux*. This spraying ought not to last longer than a few minutes. It is much less disagreeable than the actual cautery, and, what is more important, it is followed by instantaneous disappearance of the pain. Ordinarily one seance suffices to cause the pain to completely disappear; sometimes, nevertheless, a second seance is necessary; but always after the first seance the pains are considerably lessened. When you prolong the spraying a little too long, you produce vesication.

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## VOMITING OF PREGNANCY.

The latest remedy for the obstinate vomiting of pregnancy is the hydrochlorate of cocaine. Dr. Holtz (*Algem. Med. Wochenschr.*) says that in a case where, everything having failed, he had determined to produce abortion, but at the last moment thought of cocaine. He gave the patient 10 drops of a 3 per cent. solution, and had the satisfaction of finding the vomiting under control.—*Nat. Druggist*.

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## VENEREAL WARTS.

Nusbaum treats venereal warts by washing them thrice daily in salt water and afterward sprinkling them with calomel. The mild chloride of mercury in contact with the chloride of sodium is converted into bichloride, which is the remedial agent in the treatment.

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## ENURESIS NOCTURNA.

Dr. Willim says (in the *Med. Chirurg. Rundschau*) that in the nocturnal enuresis of childhood he has found no remedy to equal the tincture of the sesquichloride of iron in doses of from 5 to 10 minims administered three times a day.



# THE PEORIA MEDICAL MONTHLY.

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THOS. M. MCILVAINE, A. M., M. D.,

*Editor and Publisher.*

204 S. JEFFERSON St., PEORIA, ILL.

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\*\*\*The Editor is not responsible for the statements or opinions of contributors.

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\*\*\*All exchanges, books for review, and communications must be addressed to the Editor and Publisher.

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## EDITORIAL.

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### A HORSE OF ANOTHER COLOR.

The belligerent members of the American Medical Association claimed and exercised the right to revise, amend and alter the work of the original committee on the International Congress, and they did alter it with a vengeance by virtually kicking the old committee out of office and starting over again. Now the new committee do not propose to have anyone criticize, revise, amend or alter their work, and consequently have resolved "That the actions of this Executive Committee are final, not being subject to revision, amendment or alteration, either by the Committee of Arrangements or the American Medical Association." We do not believe this resolution, however, unanimously adopted by the committee, will save them from a general overhauling at the St. Louis meeting in May, 1886.

This is a funny world, my masters, and doctors are about as funny a set of inhabitants as it contains, especially when they get to fooling with ethics.

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### A PLEASANT PARTING.

The occasion of the removal of Dr. J. Perrin Johnson from this city to Sioux City, Iowa, was made the occasion of an elegant banquet tendered him by his fellow-members of the Medi-

cal Society at the National Hotel, October 1st. The resolutions given below will show the esteem in which Dr. Johnson was held by his co-workers in this city, where he has been the leading oculist and aurist for over twenty-five years. We feel very sorry that Dr. J. has left us, but we know that it was for his own benefit, as he owns a large stock farm about forty miles from his new home, to which he could not give the needed oversight at this distance.

The professional as well as social abilities of Dr. J. will soon, no doubt, make him as great a favorite among the physicians of Sioux City and surrounding country, as he was in Peoria.

The following are the resolutions which were unanimously adopted by the Society:

WHEREAS, The members of the Peoria City Medical Society have learned with profound regret of the intended removal of our able, highly respected and genial colleague, Dr. J. Perrin Johnson,

*Resolved*, That in the severance of the ties which have bound him so closely to Peoria for the last quarter of a century, we feel that it loses a public-spirited citizen, a man of advanced views and strong convictions, who in all the relations of life has well and faithfully performed all the various obligations which his prominent position imposed; a man eminently truthful, honest and conscientious, warm in his attachments to friends, tolerant and magnanimous.

*Resolved*, That in his removal our profession loses its most talented and accomplished member in the department to which he devoted his energies, the Medical Society one of our most valuable and esteemed colleagues, and one of its most active and esteemed members.

*Resolved*, That a copy of these resolutions be furnished Dr. Johnson, and that they be published in the PEORIA MEDICAL MONTHLY.

Dr. J. was also an active member of our State Medical Society, and we venture the opinion that the Iowa State Medical Society will soon acquire an active and popular member.

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## METHODS OF PRACTICE.

We herewith give several illustrations of methods of getting practice—the Turk has about as good a way as any and he has

no ethical scruples to bother his conscience. The homœopath is also clear of such hindrances, and Dr. Smoothtongue works strictly under the code.

## I.

"I see you have a new doctor at your house." "Yes, my wife won't have anyone else now, since Smoothtongue made his first prescription for her." "Why! did it do her so much good? What was it?" "Well, you know, she had headache, or neuralgia, or something of that kind, and went to him for a prescription: he looked at her, gave her some stuff, but told her she would never get well until she had a new bonnet. That settled him as our family doctor for life."

## II.

A homœopath in a city not a thousand miles from here, attempts to work up business in the following manner: A new family moved to town, he made their acquaintance slightly, noticed a married daughter was in an interesting condition, counted up her time in his head, and waited until he thought her term had nearly expired, then made a friendly visit. Told the mother and daughter that the city air was prolific; women always got that way when they came to town (with significant glances at the daughter), told of how many cases he had attended in the past month and how many he was engaged for, and after telling them where his residence was, took his departure, feeling sure of a call in a short time. But he overreached himself; the family *had* intended to employ him but his visit so disgusted them, that when her time came they sent for a "regular," and the homœopath is still wondering why Mrs. ——— has not been sick yet. (*True story.*)

## III.

The other day in Galata a man fell in some sort of a fit on the street. A great crowd gathered, shutting out the air, but some superstition kept them all from lending any aid. The accident happened within a few doors of a doctor's office, and the doctor stood on the steps, looking on in an interested way, but making no movement toward going to the sufferer's assistance, though urged strenuously to do so by the bystanders. He was

a Greek, and I had met him on one of the little coast steamers that ply on the Black Sea. He was little and dirty and black, and his specialty was "herbs."

He smiled when he saw me, and made a place for me on the steps. "You do not seem anxious to take the case," I said, with a glance toward the corner. He shrugged his shoulders and smiled again. "What is the use?" he said simply, "the man has no money, and his friends make no gifts." "But do you take no cases until the fee is advanced?" I asked. He replied with the counter question, "In your country do men work for nothing?" In the meantime the man died and his friends carried him away.

Now, this little Greek doctor was no more hard-hearted than others of his profession along the Mediterranean. The healing art in Turkey is done on a strictly cash basis, that is all. There is no sentimentality that makes a Turkish doctor get up in the night to go out and alleviate the sufferings of a sick pauper where he knows the patient to be such. It is cash down or no cure. This, of course, is only with the poorer class of patients. With responsible parties a diametrically opposite course is pursued. No fee is demanded from them, and it would be considered very bad manners in a doctor to bring them in a bill. The payment comes from them to a physician in the form of a gift, as if his service had been wholly voluntary and the return a consideration of esteem. Still, it is commonly paid on the spot, and is, as a rule, fully as much as the doctor would have dared to charge.

The number of regular physicians in Constantinople is strictly limited, and many of them are foreigners. Every doctor has his own territory, into which professional etiquette allows no other physician to intrude. Each one makes a daily round through his territory, beating up patients in the coffee-houses and the streets; and woe to the well-to-do man found ailing on the route. He is taken in hand unceremoniously and subjected to an examination that seldom fails to end in some sort of treatment or other. Besides the regulars, there are an innumerable number of specialists and quacks who cut in on prices and peddle all sorts of nostrums. They recognize no limitation as to terri-



tory and take practice wherever they can find it. I have seen the same vender practicing and crying his wares in Stamboul, Galata and Scutari.

All the common cases of blood-letting and headache go to the barbers, who also pull teeth, and all classes indiscriminately patronize the dervishes and shrines. It is only in cases of fever and colds and other standard troubles that the regular physician is called in at all. Perhaps after all it is as well that this is so, for the regular physician in Turkey is expected to exhibit a preternatural sagacity that would certainly fail him if the range over which it is exercised were wide. When he is called to see a sick person he is not allowed to diagnose the case as a western physician would deem necessary. He is supposed to know as soon as he sets eyes on a patient what the matter is with him, and any hesitation would be deemed a confession of ignorance.

A little Irish doctor told me with wrath in his breath of a case which he had attended, where from looking at the patient, he seemed to have a fever and be suffering great pain. The usual remedies failing to give relief, a closer examination showed that the sick man was chary of moving his left leg. This, being uncovered, proved to be broken and mangled and horribly swollen. The doctor's indignant question, why they had not told him this at first, elicited the contemptuous answer that they had supposed he knew his business, and thought of course he had been treating the patient for the trouble from the first. And before he could throw up the case and gracefully retire, they discharged him for incompetency.—*Constantinople Letter*.

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## RECEIPTS.

ILLINOIS—Drs. F. C. Gay (2.00), December, 1885; Thos. Temple (2.00), May, 1886; H. Kruse (2.00), May, 1886; W. A. Mansfield, (2.00), May, 1886; J. J. Reaburn (2.00), November, 1885; G. M. Blackburn (2.00), September, 1885; Thos. D. Washburn (1.00), January, 1886; Henry W. Hewett (2.00), May, 1886; E. Schwartz (1.00), October, 1885; G. P. Ransom (2.00), March, 1886; E. E. Reynolds (1.00), October 1885.

IOWA—Drs. J. P. Johnson (3.00), May, 1886; J. Richardson (1.00), October, 1885.

NEBRASKA—Dr. S. W. Dodge (2.00), May, 1886.

WISCONSIN—Dr. C. H. Frost (2.00), January, 1886.

KENTUCKY—Dr. B. L. Herndon (2.00), January, 1886.

KANSAS—Dr. J. D. Bryan (2.00), December, 1885.

# THE PEORIA MEDICAL MONTHLY.

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## ORIGINAL COMMUNICATIONS.

### RESULT OF SYSTEMATIC TREATMENT IN NASO-PHARYNGEAL CATARRH AND CHRONIC SUPPURATION OF THE MIDDLE EAR.

BY N. R. GORDON, M. D., SPRINGFIELD, ILL.

The opinion that naso-pharyngeal catarrh is incurable is proven erroneous by the light of experience and investigation. My observation in the treatment of catarrh justifies the following statement: that naso-pharyngeal catarrh is more amenable to treatment than any other chronic disease.

Catarrh is a very prevalent disease; by some it is regarded as a necessary evil or an inalienable legacy. This is incorrect: it is the result of abnormal action in the tissues and stands in the relation of cause to effect. Numerous patent nostrums are on the market for the cure of catarrh, and physicians often for the want of a better remedy advise the use of salt and water, cubebs, chlorate potash, golden seal, all of which though they may give temporary relief, only result in harm in most every case.

The nasal organs were not designed for douches or receptacles for snuffs or irritating powders. We will report a few cases from our note-book treated by the warm spray method that the reader may judge of the results. It must be remembered, the following cases had all been treated by the usual orthodox method, as recommended in standard works.

*Case 1.* A bright looking girl, 11 years of age; affected with naso-pharyngeal catarrh for five years; the secretions would harden in the nasal chambers and require considerable effort to expel them; her breath was so offensive that other members of the family refused to occupy the same bed with her. She complained of pain between the eyes and in the frontal region; her health was being rapidly impaired by the disease. She was an adept in the use of the douche. She was treated during August, September and October of '83, and a few times during the winter and following spring, when she was dismissed. She improved in flesh from the first, and is now free from all the troublesome symptoms of catarrh.

*Case 2.* A single lady of 20 years; had catarrh for five or six years; has used many of the patent nostrums; had been failing in health during the last year, and her friends feared she would have consumption. I treated her by the warm spray method during September, October and November of '83, and again in the following spring, for three weeks. She rapidly improved in health and gained ten pounds in weight during the first term of treatment. I gave her a tonic, although she had taken a tonic before coming to me with no effect, and therefore it is proper to conclude the local treatment was the right thing. She remains well to-day.

*Case 3.* A boy of seventeen; catarrh for three years. Mornings while making effort to clear out throat he would often vomit; the secretion was very tenacious; he took cold very easy, and, indeed, was rarely ever free from fresh cold; complained of fullness in the head and general feeling of malaise. He was treated for two months, again in following spring, and at present writing, eighteen months from last treatment, feels perfectly well.

*Case 4.* A married lady, twenty-nine years of age, always had good health until the last six months; was treated by her family physician for laryngitis and incipient phthisis. She was much alarmed about her condition, fearing consumption. She complained of burning sensation in larynx and a slight cough, with loss of appetite; unable to sleep more than four hours during night. Upon examination of pharyngeal space I discovered that she had catarrh. She was treated for six weeks, during which time she rapidly improved, gaining seven pounds in weight. She

remains well at present date, fourteen months after treatment, and is able to attend to her duties in the school-room.

*Case 5.* A widow lady, age 36, with great effort came to my office. She was confined to bed and room for four weeks previous with violent cough, fever, pain in larynx and loss of appetite; was reduced in flesh and strength; was told by her physician she had consumption, and the inference was, must die. She was treated more or less for three or four months, giving her warm spray inhalations in connection with treatment of naso-pharyngeal space and general tonic remedies. She is now well and supports her family by her own industry.

Cases four and five are given to illustrate the fact that catarrh often produces symptoms simulating incipient phthisis; that physicians may be misled into an erroneous diagnosis and treat them as consumption; that the warm spray method gave them relief from the first treatment and positively cured them, as the patients are well and hearty to-day, with no indication of tuberculosus.

Chronic suppuration of the middle ear is usually dependent upon inflammation of the naso-pharyngeal space.

*Case 6.* A single lady of 24, very frail in general appearance; discharge from right ear for six years; had catarrh for the same length of time, if not longer. Large quantities of semi-transparent mucus is discharged from post-nasal cavities; her health is poor, feels despondent, and thinks but little can be done for her. The discharge from ear is muco-purulent and rather copious. The naso-pharyngeal space was treated daily for two months, after which time she was obliged to return home. She was given a home treatment, which she uses at times. Ear treated by Politzer's method and boric acid. She informs me fifteen months from date of last treatment, has no discharge from ear, and her throat gives but very slight trouble, general health improved and her weight improved twelve pounds.

*Case 7.* Is 26 years of age; has discharge from left ear for fifteen years; the hearing in affected ear entirely destroyed; had catarrh for a long time. Gave same treatment as case number six but continued it six months; last treatment was given one year ago and no discharge from ear since.



## ENLARGED TONSILS.

BY J. S. GEIGLEY, M. D., CANTON, ILL.

Of all the chronic affections of childhood and early youth, this is perhaps the most common; and while in itself, when not existing in a great degree, does not give rise to any great amount of inconvenience, it at the same time renders the person affected peculiarly liable to certain throat troubles, and constitutes a grave complication in several of the diseases of childhood, such as scarlatina, diphtheria, etc.

Enlargement of these glands may be due to one of several causes, the most frequent of which is an antecedent inflammation (quinsy) followed by chronic inflammatory hypertrophy of the glandular elements, or a diathetic condition of the individual, in which there is a proneness to enlargement in the glands of the body the tonsils merely keeping pace with its fellows in other locations. This may be illustrated in those healthy, robust persons who have enlargement of the tonsils, but who exhibit no indications of glandular enlargement elsewhere. These persons will tell you that they have an attack of "bad sore throat" almost every season, and that it usually terminates in suppuration. In such cases the disease is purely local, and will, if left to itself, terminate in complete shrinkage of the glands through repeated attacks of suppuration and slough, by the time the individual has reached middle life, leaving him, however, with a chronically inflamed throat studded with enlarged follicles, and peculiarly liable to acute attacks of inflammation at every change of the weather.

If we examine the throat of one of these cases, we will see the tonsils projecting beyond the pillars of the fauces toward the median line. They are usually globular, of a dusky red hue, and scattered over their surface are numerous little ulcers in various stages of cicatrization. The pillars of the fauces, soft palate, and retro-pharyngeal wall, partake of the red hue of the tonsils, and the latter is usually studded with enlarged follicles. The breath is generally offensive, owing, no doubt, to the decomposing sebaceous matter in the crypts of the tonsils and folds of the palatal mucous membrane.

Now in those cases of enlarged tonsils where there is a predisposition to glandular enlargement throughout the body, careful

examination will reveal a different state of things. These patients are usually pale, anæmic, and the scrofulous tendency is well marked. There may, or may not be a history of all antecedent quinsy, but if they are children the parents will tell us that they are frequently disturbed in the night by the child's loud breathing or snoring, and that sometimes there seems to be imminent danger of suffocation: they always sleep with their mouth open and generally breathe through the mouth when awake: in some there is a purulent discharge from the nose and the voice has that peculiar tone due to usual obstruction, and in not a few of these cases we will find a considerable degree of deafness existing, the cause of which is obvious. Inspection will usually reveal two lobulated masses projecting into the pharynx, generally pale, with portions almost pearly in color, and with numerous little crypts opening upon their surface. Many times the only evidence of inflammation about the throat is along the border of the soft palate and pillars of the fauces, due merely to the displacement of these organs by the enlarged tonsils.

In regard to the treatment of enlarged tonsils, there has been considerable difference of opinion, while some pin their faith entirely to local applications in the way of caustics, astringents, etc., with constitutional treatment with tonics and alteratives, others do not hesitate to express their utter lack of faith in these measures, and recommend excision as the only procedure that can give the patient assurance of relief. Now while I am rather inclined to the latter belief, still I think in the first mentioned class of cases of tonsilar hypertrophy, due to repeated attacks of quinsy, and where all the surrounding structures are chronically inflamed, and where the tonsils are not so large as to constitute an impediment to restoration, much can be accomplished by the use of drugs. I usually begin the treatment of such cases by brushing over the tonsils and neighboring structures with a solution of nitrate of silver, twenty grains to the ounce, once or twice a week. Meanwhile the patient uses a gargle of the following mixture:

R.	Sodis Borat )	aa	2 drachms.	
	Fl. Hydrastis )			
	Pinus Canadensis (white) )	aa	½ ounce.	
	Glycerine )			
	Aqua q. s.	ad	4 ounces.	M.

SIG.—Teaspoonful as a gargle three times a day.

If there is a catarrhal condition of the nasal passages, they are sprayed with the above mixture once a day. I also direct a vesicating mixture composed of croton oil, tinct. of iodine and comp. spts. æther, to be applied over the tonsils on the outside of the throat every few days. This treatment has answered admirably in several cases for me.

But when we come to treat true tonsilar hypertrophy, we have to deal with an altogether different matter, for instead of two soft, fluffy, ulcerating glands, we have two hard modulated, fibrous bodies protruding into the pharynx, that will resist every effort toward their removal by the application of drugs. In these cases surgery alone can offer to the patient assurance of a radical removal of the difficulty. In my experience remedies directed toward the eradication of the constitutional vice that causes the glandular enlargement, has accomplished very little, if anything. In one case, that of my own child, I gave them a thorough trial, but the result was *nil*. I was finally compelled to resort to operation to prevent suffocation. I also think, that when the tonsils are large enough to impede nasal respiration, the sooner they are removed the better—that is, after the child has reached the age of three years. I am aware that this is contrary to the advice usually given in the books, but I cannot see the use of waiting until the child has passed the age of six, for there are very few children of any age that will permit an operation without an anæsthetic, and besides, the mechanical effect of the enlarged glands may produce serious changes in the organs of voice and respiration, to say nothing of the various other troubles that they may give rise to.

Now, as to the best method of removal of enlarged tonsils. In my opinion the tonsilitome is *not* the instrument to use. I have had no experience with any but Fahnestock's, and that in my hands was a complete failure. I have tried it in several cases, but could only succeed in detaching a thin slice from the tonsil which did not materially reduce its size, neither have I been able to pull the gland through the ring with a tenaculum, as some claim can be done, the aperture being too small, but if it had been larger I don't think the instrument could be got into the throat. Of course there are some cases in which the tonsil-

itome would do the work, but I prefer in all cases a simple probe pointed, curved bistoury, and a cross-action, vulsellum forceps. The bistoury should have a stiff handle with a rather long shank and a cutting edge of not more than an inch and a quarter, but with rather more curve than usual. My mode of operating is this: The patient, if an adult, is seated facing a good light. After placing the tongue-depressor and giving to him to hold, the operator seizes the left tonsil with the forceps and makes slight traction toward the median line, then the bistoury is carried above and behind the tonsil, which is severed from its connection with the pharynx by a cut downward and slightly inward. After waiting a few minutes for the hemorrhage (which is usually very slight) to subside, the right tonsil is seized in the same manner as before, but unless one is ambidexterous he will experience some little difficulty here, for the left hand holding the forceps is in the way of the hand holding the knife. But if the left arm be held high, with the elbow looking upward, it is out of the way of the knife, which is used under the curve formed by the arm.

In children, I always use an anæsthetic. It saves time, and the child is not made sick by its struggles to resist. It always looked inhuman to me to see a doctor work with a screaming, struggling child, and finally frighten it into convulsions, as is not infrequently done. After the child is anæsthetized a pillow is placed under the shoulders, so that the head is in the same position as for tracheotomy. An assistant, standing at the patient's left, holds the tongue depressor, and the tonsils are removed as before described. As soon as the gland is out, the little patient is turned on the side. This allows the blood to run out of its mouth and prevents the same from entering the trachea. I usually remove but one tonsil at a time in children. While both might be removed at one operation, I think it increases the risk, and as the removal of one always relieves the urgency of the symptoms, I think it best to allow an interval of two or three weeks to elapse between the two operations. Some writers advocate the removal of only a part of the gland, expecting atrophy of the remainder: but why not remove all of it while we are about it? It certainly saves time, and I cannot think that it increases the danger to the patient, unless it would be through hemorrhage: but in all of my cases—some twelve or fifteen—I removed the glands completely,



the bleeding being but very trifling in each case. The after treatment of tonsilotomy is very simple. The majority of cases will need nothing but a diet of bland and unirritating substances for a few days, although I usually throw a little iodoform over the stump of the tonsils by means of a powder blower.

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## SOME THOUGHTS ABOUT PNEUMONIA.

BY J. D. EBERT, M. D., DUNDEE, IND.

I wish to briefly discuss in this paper the probable causes of pneumonia in a great many instances and the treatment, which to my mind appears to be logically adapted to each stage when coming up, especially as a complication with any of the malarial troubles. The subject of pneumonia, however, in all of its details, physiological and pathological, is a broad subject. So much that in the brief space allotted in this paper, I will only be able to call up the points of special interest and dispose of them very briefly. Especially at this season of the year pneumonia is endemoteric. Any one of the three varieties or forms of malarial fevers, are subject to a complication of a dangerous pneumonia, ushering its insidious symptoms in at each recurrence of the cold stage. This condition is pneumonitis, coming as a complication with a malarial form of fever, necessarily has for its prime factors two grand causes at least: and may have many minor or incidental conditions, growing from and out of this very condition of patient, as secondary causes and effects, and after the congestive stage is fully reached, marked by the unmistakable rusty expectoration. The case is no longer strictly a malarial condition, nor can it return to such a condition of things, until the metabolic force of the system is normally adjusted. The para bysmaic condition of the lungs resulting in the engorgement of lung tissue and air cells as well as mucus membrane all by consequent infiltration, of course suffers violence, both functional and structural. Pneumonia in all of its conditions when as a complication has for its pathological conditions: First, a vito chemical factor, viz.: A bacterial influence exerting a very direct depressent effect on the great sympathetic nervous system, destroying the dynamic force proper, culminating in the en-

gorgement of the softer tissues of the body: hence the lungs are very likely to be the seat of congestion: holding as the pulmonary organs do, a very intimate relationship physiologically to external causes, which in this changeable climate is almost an unavoidable condition to be considered, as a bad cold is invariably present.

These two prominent causes combined with a stenthic condition of the blood, normal in quantity, but deteriorated in quality, produced both by the presence of bacteria, acting chemically, vitally, and mechanically. The liver in its three-fold duties becomes embarrassed with the unnatural demand made upon it, that of dealing with those infinitely small, though countless entities, producing pathological changes in the blood. Acting both primarily, and reflexly, implicating the liver in fault in all of its functions.

The very strange behavior of bacteria in the human system are very much modified in their effects by pre-existing or chronic troubles. Perhaps as yet, the special law that governs those little creatures is imperfectly understood by the pathologist of our day.

When the blood-making process of the system is impaired by disease, as we have it in the continued form of fever, being announced by the failure of the appetite and power to digest food properly, we may very easily conclude that the blood-using process of the system is also impaired, and that the formative vessels are unable to use the already stored plastic material. Just how long the system can retain plastic material unused under its vital command without producing functional and subsequent structural disturbance I am unable to say: but I am well assured in my own mind where the patient passes rapidly from apparent good health to disease, that the system is not only poisoned with bacteria but is also distressed with its own intended store of pabulum, which condition favors local congestion, and if strong and continued long enough on any organ, especially the lungs produces infiltration and effusion from the pulmonary arterioles, first of serum and finally blood corpuscles. Pathologically this condition of the lungs, according to amount of lesion, and time which effusion is existing, presents

two very important resulting factors which becomes perturbation in disease proper, and must be at all times considered in their proper sequence to properly treat the case in hand and be on the alert for future trouble.

A lung tissue which has been infiltrated, and that too by impure blood, surcharged with bacteria and effete products sufficient to inaugurate a continued form of fever, perhaps suggests another factor which has something to do in heightening the inflammatory process, and in subsequent absorption probably plays a part in producing the morbund, or typhoid symptoms, which occasionally but quickly arises to still darken the cloud caused by the effused products from the lungs being absorbed back into the circulation in the process of repair. As destructive metamorphosis of waste albuminoids gives urea proper this matter is deserving of the closest attention to see that the excretories, especially the kidneys, are in good working order, and if needed to assist a free catharsis should be produced, as urea in abnormal quantities in the blood disturbs the nerve centers and brain, producing, according to temperament, athymic or contrarywise pervigilimnic state of affairs.

In taking a brief resume of the foregoing thoughts on the complication of pneumonia, a few thoughts with reference to its treatment and its adaptation, would seem to be in order. When any of the three forms of malarial fever become at any time complicated with pneumonia, I at once leave off the special malarial remedies, such as tonics or any of the preparations of the bark, and open up a new line of warfare, as certainly sulph. of quinine or cinchonidia administered in the first or second stage of pneumonia works serious harm to the patient. Under the very pressing necessity to at once relieve the congestive trouble and cut off the third stage proper by timely and heroic treatment should be the first object, as the probable first cause, that of malaria, is a slow factor, consequently the digestive and assimilative processes must have the attention. Judging from effect to a cause, the liver in its second and third function is strongly suspected to be at fault. That the tissue food is in possession of abnormal constituents amounting perhaps to hypnosis, also sugar being found in the effused products of pneumonia, points to the glycogenic, or third function of the liver in fault.

To strike hard and a sure lick is a good motto right here, and I have found nothing better than

R.

Hyd. cum creta,	10 grs.
Powd. gum camphor,	1½ grs.
Powd. ipecac,	1½ grs.
Powd. ipecac et opii,	3 grs.
Sulp. soda,	15 grs.

M. Et. Divide into charts No. 12.

Sig. One to be given every two hours to induce free catharsis: if not, continue soda sulph., five grains every half hour, until the desired effect is produced.

Also, as a nerve stimulant and promoter of absorption, give

R.

Ammonia, muriat,	30 grs
Powd. ipecac et. opii,	5 grs.
Syrup simple,	fl. 10 drchms,

Sig. Dose a teaspoonful every two hours, alternating with the powders.

Then, as a continued treatment until the third stage is reached, when expectorants and tonics are indicated, give

Hyd. cum creta,	12 grs.
Powd. gum camphor,	3 grs.
Powd. ipecac,	6 grs.
Powd. ipecac et. opii,	6 grs.

M. Et. Divide in chart No. 12.

Sig. To be given every three hours, alternated with the above mentioned syrup, sulphate soda in five grain doses, given when necessary to secure an action from the bowels twice or thrice daily. When the third stage is fully marked by moist, although light-coated tongue, pulse down to 85 or 90, temperature anywhere between 97 and 100, with no delirium and absence of the rusty sputa, but changed to a pus-like nature, I at once prescribe,

Sulphate quinine,	16 grs.
Powd. ipecac et opii,	2 grs.
Powd. ipecac,	2 grs.
Camphor powd.,	4 grs.
Sulph. soda,	8 grs.

M. Et. Divide in charts No. 8.

Sig. One to be given every three hours alternated with



Syr. scilla.,	8 drs.
Syr. stillingia,	8 drs.
Syr. senega,	4 drs.

M. Sig. Dose two-thirds of a spoonful between powders.

This paper having already become so very lengthy, I close.

## THE FINANCIAL PROBLEM.

BY W. S. STRODE, M. D., BERNADOTTE, ILL.

As this question is being considerably agitated and discussed by the various medical societies and journals throughout the country, a description of the plan adopted by some of the physicians of this county may be of interest to the readers of THE MONTHLY:

Each doctor prepares from his books a list of the "no pay" patients, which he exchanges for like lists with the neighboring M. D's.

When the "dead beats" come out of their way for treatment, as they will generally do when pressed for settlement, we are able, by referring to our "black list," to know their standing and treat them accordingly—as a rule demanding the cash or satisfactory security for treatment. We expect, by adhering to this plan, to be able in time to do away with a large part of the "no pay" practice, which now constitutes from one-third to one-half of all the business we do, and which is a dead loss to us. This class of patients, as every physician knows, is the most exacting, requiring the greatest amount of medicine and attention of all the people with whom we have to deal (except the hysterical females).

But there is another fact which is very patent to those who have tried it on these "ne'er do wells," and that is, when sick they will have treatment, even if they have to skirmish around and get something to *pay for it*. Some persons urge that this plan is hard on the poor. But this argument is sentimental nonsense, and it is such nonsense, coupled with the credit system, that encourages and perpetuates the great army of "tramps" and "dead beats" that our land is full of.

Any man with health and strength can pay his honest debts if disposed to do so. But that law protects him if he chooses not to pay.

When well he is independent of the doctor and when sick if one physician will not attend another will (so he argues). And hence it becomes necessary that we do something to protect ourselves.

It is to be hoped that this question will be agitated by our profession until a law is enacted by our Legislature recognizing a physician's services as labor and making it possible for us to collect our fees.

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## CORRESPONDENCE.

### PHYSICIANS THEIR OWN DISPENSERS.

*Editors Peoria Medical Monthly.*

DEAR SIR:—Why is it that so few medical men see fit to dispense their own medicines? Several years ago, if I mistake not, your journal editorially and through correspondence advocated the plan and I have since adopted it with the most gratifying results.

In this day and age of keen legitimate and illegitimate competition it is necessary for the ordinary general practitioner to look to his own interest as sharply as possible, and in no way, in my estimation, can he do so with more pronounced effect than in judiciously dispensing his own medicines. It is true there may be some slight disadvantages connected with the plan, but certainly they are vastly counter-balanced by the advantages arising therefrom.

As for myself, I find it just as convenient to drop out into a glass a sufficient quantity of concentrated tincture, or fluid extract at the bed-side, as to write a prescription: and it is always infinitely more satisfactory to the patient, sometimes highly advantageous to the urgency of the case, and is almost invariably placed emphatically to the credit of the doctor. And such opinion on the part of the patient is not unreasonable at all. Many a time and oft have seen bottle after bottle secured at the drug store arranged in the order of arrival on the table in the sick-room with their contents only partially gone, but each one representing a sum of money which in many instances would have been much more cheerfully used to liquidate the doctor's

account, had he been shrewd enough to himself provide the necessary medicaments and thus add even a small percentage to the sum total of his collections.

Frequent changes of prescriptions secured by patients at the drug store make sad inroads upon a moderate purse, especially when sickness is long continued, and the physician is sure to be ultimately the sufferer. In the main fancy, or so-called elegant preparations, together with bottles, corks and labels, are quite unnecessary and expensive luxuries. Glasses, cups and paper will usually answer an excellent purpose as receptacles, and no more need be prepared than will suffice for administration against the next regular visit.

Frequent changes of medicine, while that previously prescribed remains unused, is considered by the patient as evidence of indecision and professional ignorance, and too often leads to a sense of doubt and fear, detrimental alike to patient and medical attendant. These unpleasant features can with certainty be avoided by dispensing one's own medicines at the bed-side, and in quantities sufficiently limited to admit of necessary change without exciting morbid apprehension on the part of the patient. Homoeopaths and other irregular practitioners are quick to discern these factors in the make-up of human nature, and to fully profit by the knowledge thus acquired. These are facts which it is quite in place for scientific physicians to take into consideration for the benefit alike of themselves and their clientage.

Again, it is almost always possible to secure the immediate payment of a moderate fee when the medicine is included, but often very difficult to secure it without. The average man recognizes the merchantable character of drugs at once, and feels that of necessity they must be paid for, but the pecuniary value of knowledge and skill is to him far less tangible and he fails to see that he is by right just as responsible for a speedy settlement. As to this particular matter I know whereof I speak, for I have had an extensive experience which has taught me the wisdom of the course which I am now advocating. Hand the average man a written prescription and he will assume a distant, far-away look which bespeaks a mental computation of the druggist's charges,

whilst the just claims of the physician are not thought of: but hand him, on the contrary, a package of medicine, and his everyday business instinct leads his hand directly to his pocket, and in nine cases out of ten the fee is forthcoming. As I said above, these are not fancies, but facts collected from everyday experience. If we are to maintain our reputations as scientific thinkers and workers, let us also adopt scientific methods in securing our just pecuniary as well as professional deserts. Fancy fees and fabulous *honorariums* are not the lot of most of us, and it behooves us to collect with scientific exactness the just claims which we may hold against individuals. The *easiest* and most *inoffensive* ways to do this are the most scientific and agreeable, and I sincerely believe the above to be *one* of those ways.

But, there are other reasons why physicians should dispense their own medicines, among which may be mentioned its influence for good upon the mind of the patient. Many persons are morbidly sensitive on this point, and such is another potent factor in alienating the affections of many from the regular practitioners. A distrust, no doubt in the main illy founded, exists in the minds of many as to the reliability of ordinary apothecaries, and this distrust exhibits itself frequently by a hearty acceptance of the services of him who dispenses his remedies at the bed side. This is a state of affairs emphasized in the experience of every medical man who chooses to think, and thousands of illustrations might be gathered daily.

Many more features of this question might be brought up, but for the present, at least, I forbear. I have no *peculiar* views or opinions to foist upon a long-suffering profession, but wish simply to thus bring this subject again to the attention of those of our profession who may care to profit by it.

As your paper is a *practitioner's* journal, anything of interest to them will no doubt be acceptable, and for the purpose of *mutual* benefit I invite criticism and suggestions.

I am, sir, very truly,

A. E., M. D.

#### MEDICAL PRETENSIONS.

*Editors Peoria Medical Monthly.*

Pretensions are not only intentions to deceive, but are in many instances ridiculous. A man who uses expressions of



which he does not know the full meaning, makes himself ridiculous and tries to palm himself off as a higher educated man than he really is. This is self degradation in the eyes of those who know better.

If a man reads an article in a medical journal with pleasure and interest, and arrives in reading at an ungrammatical, ill understood latin or foreign expression, it spoils all the lustre of the author of the article.

If the colleges, which are private institutions, which assume the right to judge the ability of their disciples to practice their chosen profession, know what preliminary knowledge is necessary, and do, notwithstanding, pass a favorable judgment on those wanting such knowledge, and crown it with a final document written in a language the receiver does not understand, such an act falls under the head of pretensions and is deceiving and ridiculous.

It is an open question, in such a practical land, whether mathematics, physics and a little Latin, and even Greek, constitute a needy preliminary knowledge to the physician, as it is looked upon in Europe, where a profession means a vocation requiring the highest possible school-education.

It is true a physician may treat a patient successfully without knowing how to spell erysipelas correctly, but to call that man a member of the profession is a humbug.

The sciences used in any professional study are full of latin expressions, by reason of the presumption that latin is the general language understood by the learned men of all the civilized nations, and of the sense defining character of that, by no means dead, language. On that account alone the knowledge of latin may be the necessary evil for truly professional men. There are occultists who have not the slightest idea of a mathematical equation.

America can show up most favorably with quite a number of medical men in comparison with the highest in Europe in skill, knowledge and education. But still we are silenced many a time by some overbearing Europeans, denying us equality as a profession. Though such men are somewhat ungentlemanly, we are forced to excuse them.

America is thoroughly practical. A man may learn the topography of the ovaries without being able to write his name, and may by chance observe repeatedly the operation of ovariectomy, so that he may successfully operate, though he may never have been anything else than a renowned horseshoer. Such a man the doctors (?) call a quack.

But where does the quack commence, or does he end at present at the college—door?

A man may expose in frame the finest diploma in latin, and may have forgotten what he has, or has not learned, and has not studied since *anno tabac*, when he was made a doctor (*misericiordiæ*) but he must be acknowledged a man of the syringe because his diploma says so.

(?) Dr. means learned man, able to impart his knowledge.

If a man cannot compare favorably with other physicians, he must at least be not a general ignoramus, if he shall not stand below the dignity of the above mentioned horseshoer.

For the so often mentioned care of the health and safety of the public, it would be desirable to have a State board of examiners whose duty it should be to examine all the physicians in the State, say every ten years, for the reason that even the best man may be so unfortunate as to have his mental faculties impaired incapacitating him for practice. This would look like a cruel proposal, if I would not be convinced of the charitable help of the profession for the unfortunate brother, if need be.

Farther, even if such an examination should prove a farce like the pharmaceutical examination in Iowa, it would deter many an incompetent man from appearing before the board.

The aim of the practice of medicine may be lucre or bread and butter, but if it is not combined with love to study or the humane desire to do some good, it is the most despicable business imaginable.

E. BRENDAL, M.D.

Cedar Rapids. Iowa.

NAPHTHALINE FOR OLD ULCERS. (Dovodtchikoff in *Vartch*). Dust on thrice daily; wash the old dressing off before each new dressing; cover the ulcer with oiled silk. -*St. Louis Med. and Surg. Jour.*

## SOCIETY TRANSACTIONS.

## CHICAGO MEDICAL SOCIETY.

(Concluded from October Number.)

Stated meeting, September 21, 1885. The President, C. T. Parkes, M. D., in the chair.

"Laparotomy in a Case of Gun-shot Wound of the Intestines" was the title of a paper read by Dr. Augustus V. Park. He said: M. S., a butcher-boy, aged 16, of slight stature, formerly in poor but lately in good health, was shot on September 1st, 1885, at 3:30 P. M. A pistol-ball, of calibre 22, fired from a distance of forty-five feet, entered the abdomen at a point midway between the symphysis pubis and umbilicus, two inches to the left of the median line. The patient was removed in a farmer's spring wagon from the place where he was shot to his home, a distance of seven miles. A dressing was applied, and at 1 P. M., the next day, he was taken to the Michael Reese Hospital. The patient arrived nearly exhausted; his temperature was 100 degrees F., pulse 130, weak and intermitting. His respirations were 30, his abdomen tympanitic especially high on left side. There was no liver dullness, giving rise to a theory that the liver was crowded upward by extravasated blood. At 1:30 P. M. laparotomy was performed, the incision being made directly over the seat of the wound. We could not find any wound of the peritoneum, or where the ball passed through it. As the peritoneum was opened, decomposed blood rushed through the opening with great force. Blood and blood-clots which quickly formed were removed with sponges; the intestines were drawn out and examined for wounds. The first wound found was an abrasion, the ball not having entered the intestine. There was but little hemorrhage, and the wound was closed by the interrupted cat-gut suture. The second wound, half an inch in diameter, opened directly into the intestine. A small mesenteric artery was found divided and tied. All hemorrhage ceased. The wound was closed by interrupted suture; no further injury could be detected. The abdominal cavity was cleansed with one (1) per cent. solution of carbolic acid; the intestines were washed, carefully examined and returned. The abdominal incision was closed by

two sets of sutures, the peritoneal surfaces were approximated and closed by continuous suture.

At 5:30 on the morning after the operation the patient died. Seven hours later an autopsy revealed commencing peritonitis, the small intestines being apparently agglutinated together. A few blood clots and a quantity of extravasated blood were found in the peritoneal cavity on the left side. A contused wound of the rectum was found near the sigmoid flexure, the ball being deflected from this position into the muscular tissue below, where it was found imbedded. This case justifies the opinion of various eminent surgeons that we cannot tell the direction the bullet takes from the position of the wound of entrance, or exit. From the conditions existing in this case, he was of the opinion the case would have terminated favorably had he been able to perform, with antiseptic precautions, laparotomy immediately after the injury.

Dr. F. E. Waxham said Dr. Park was entitled to a great deal of credit for presenting to the Society his paper and the specimen, because it is the report of a case which terminated unfavorably. He thought the chances of the patient would have been better if he had been allowed more quiet. His frequent removals must have loosened the blood clots and increased the hemorrhage and prolonged the shock. If he had recovered he would have thought it almost miraculous, for it is one of the maxims of abdominal surgery to have complete and perfect quietude for the patient.

Dr. R. Tilley said the study of gun-shot wounds of the abdomen is interesting to every member of the profession, no matter in what particular direction his favorite studies may lead. Any one of us may find ourselves confronted with the responsibility associated with such cases when delay in action may be culpable. Relative to the case before us, he should not only not consider a recovery miraculous, but deem the conditions associated with it more favorable than, on the average, can be expected. One of the conclusions formulated by our President before the American Medical Association in Washington in 1884 is, in opening the abdomen to look for gun-shot wounds, the incision should be in the median line, regardless of the bullet



wound. This procedure certainly facilitates efficient inspection, but in the present case it was ignored. He regretted that the cause of failure of the operation has not been thrown into stronger relief, and he felt like asking our President, Dr. C. T. Parkes, to formulate the lessons he would draw from the failure of this operation. Of course, the case will go on record as one of operation after gun-shot wound of the abdomen associated with failure, and will tend to develop hesitation in the mind of the general practitioner about a class of cases which, in his opinion, called for urgent, prompt operating.

Dr. Bogue said there were a few lessons to be learned from this case. One is the advantage which would follow an early operation, before the blood, or fluid in the abdominal cavity, decomposes. An operation should be made before the irritation from this source is severe. Another lesson is the necessity of a thorough exploration of the abdominal cavity for the purpose of discovering and removing any foreign substance which may be in it. It is necessary to control hemorrhage, by opening the abdomen and having free access to every part of it.

Dr. J. H. Etheridge said that it will be noticed the pulse-rate was high after the operation, which lasted two hours. The question arises, if we cannot account for death on the opinion that it was due to the action of the ether on the cardiac nervous system. Was there acute poisoning from ether? Or was death caused by septicæmia? He wished to thank Dr. Park for the report of this case, because it is from the reporting of the unsuccessful cases we obtain the most benefit. He did not believe it would deter any one from doing abdominal surgery, as it had already taken such a rank that the report of one unsuccessful case would not intimidate any surgeon, but enable him to steer clear of difficulties others may have encountered.

The President said: Your chairman feels somewhat diffident about making any remarks, because his experience in connection with gun-shot wounds of the abdomen was solely in connection with the results of experiment upon the lower animals.

There is one fact demonstrated by this case, and it stands out in all the cases, of which I know, operated upon in man,

which corroborates the results of the experiments made by myself, and that is, the necessity of free incision through the median line of the abdomen, without any reference to the course of the bullet, as the best way to get at the injury so as to determine its extent, and to apply the means of repair as well as to secure a clean abdomen. Another item mentioned in the case is the one that blood flowed freely from the bullet wound while the patient was in the erect position and ceased when he was recumbent. As the bullet passed through parts of little vascularity, this item points to the wounding of some large vessels internally (as was found), and becomes a point of value in the question of perforation. This question of perforation is no easy one to settle positively, even in the best of hands. I am inclined to agree with Dr. Waxham in the opinion that it was not the best plan to remove the patient from his home before operating, notwithstanding his bad surroundings. We must take into consideration the fact that his patient was accustomed to his surroundings, and far less likely to be harmfully affected by them than by the danger incidental to the jolting movements of removal.

Some of the accidents of the case I am sure would have been avoided by obeying the rule of open incision in the median line. Post mortem showed considerable old blood in the cavity: this would have been found and removed. The paper states no extravasation of bowel contents was noticed: the non-existence of such condition has doubt thrown upon it by the condition found in post mortem. The wound in the rectum would have been discovered, and the action of the bowel displayed shows an untouched perforation of its walls: probably the wound of entrance of the bullet. The exit wound is sewed up.

The manner of closing the external incision, as well as the bowel wounds, should be such as to *save time* in the operation, by using the continuous cat-gut suture for small bowel wounds and single through and through suture of the abdominal incision. It is pure waste of time to unite the latter in layers.

It is a matter of some pride and great pleasure to me to know that the principles enunciated by me as the results of experiments on the lower animals (especially as they are ridiculed by some) have so recently been put to a severe but successful

application upon the human body. Dr. Bull, of New York, had a successful case of nine perforations, and Dr. J. B. Hamilton, of Washington, D. C., also a successful case with eleven perforations.

In Dr. Hamilton's case, the only bad happening arose from the formation of a blood tumor—probably, as Dr. Hamilton says, forming from a grazed surface, the bleeding from which could not be contracted. This was subsequently opened through the rectum and the patient recovered. But it is interesting to notice that the patient was in greater danger of his life from this mass of blood than from the wounds in the intestine after they had been closed. It shows also how necessary it is to prevent bleeding by securing, if possible, all bleeding points.

After the pathological specimen was examined the Society adjourned.

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### PERISCOPE AND ABSTRACT.

#### CARDIAC DISEASE IN ADOLESCENCE, CONGENITAL MALFORMATION OF THE HEART, AND ANÆMIC MURMURS.

In a clinical lecture on the above subject by Dr. John M. Keating, of Philadelphia, and reported by William A. Edwards, M.D., for the *Medical and Surgical Reporter*, the following practical points are brought out:

After describing at length the peculiarities of the foetal heart and its circulation, he says: Let us now consider this little patient, baby G., aged six weeks, female. This patient presents you a form of congenital cardiac malformation that you will probably meet more frequently and recognize more readily than any other, *i. e.*, patulous foramen ovale, occasionally *cyanosis*, popularly known as “blue disease.”

Soon after birth the foramen ovale should be closed by its valve probably contracting adhesions with the edge of the aperture, and by the equalization of pressure in the auricles. Should it remain permanently patulous, the condition which is so well illustrated before you, will arise. A small aperture may exist between the auricles without occasioning any admixture of blood, and consequently presenting no clinical history. If you will examine an adult heart carefully, you may note above the fossa ovale a muscular projection, with its concavity looking posteriorly and inferiorly. This has been designated the valve of

Vieussens. It is continuous below with the Eustachian valve. The appearance of these two crossing arches is not unlike a pair of scissors, and in some cases will enable you to introduce the handle of a small scalpel from the right to the left, but when the auricles undergo systole the aperture is closed, and, as above stated, there will be no admixture of blood,

Patulous foramen ovale appears to be more frequently seen in females, and our case helps to bear out the rule.

This malformation may produce no disturbance until the auricular insufficiency has had the same effect that you know a continued mitral insufficiency will have, the heart then suffering from a systole and deepening the cyanosis, and bringing the œdematous symptoms prominently forward. A case is recorded in the medical journals of a man reaching 66 years with a patulous foramen.

Every case that you meet will not present you such a clear and easily readable clinical picture as the one that you now have the opportunity of witnessing. In certain cases the diagnosis can only be suspected.

A clinical observer tells us that in a case of his, "A little girl suffering from palpitation of the heart, in whom the beginning of a systole was indicated by œdema and venous stasis, a soft, deep-blowing systolic murmur was present to the right of the sternum, in the second intercostal space, due probably to a persistence of the foramen ovale."

Another condition worthy of your study, of which unfortunately I have no case to illustrate, is a *persistent patulous ductus arteriosus*. As I stated at the commencement of my lecture, the canal is not obliterated immediately after birth. \* \* \*

I would consider the persistence of the ductus arteriosus thirty days after birth as constituting a congenital malformation, but remember that a patulous duct is not inconsistent with the maintenance of life. \* \* \*

The symptoms of patulous ductus arteriosus are more respiratory than directly cardiac, and do not show themselves in early infancy, Generally about the second, third or fourth year they commence to attract attention, being more noticeable after exertion. This grows progressively worse, the patients on the merest exertion being seized with suffocation, the skin becoming deeply engorged. Remember, if you please, however, that cyanosis is not constant, but occurs paroxysmally, appearing and disappearing, as he exerts himself or is in repose. Duroziez records a case in which cyanosis was almost the last scene of the final symptoms.

The diagnosis of these cases is, of course, not easy: ill-defined blowing murmurs are generally heard, but they are diffi-



cult to locate and interpret correctly. In some cases recorded by reliable observers, no blowing murmur was present at all.

The course and prognosis in these cases is much the same as organic heart disease. More particularly in regurgitations of the auriculo-ventricular orifices, the mitral or tricuspid valves.

After describing some rare pathological conditions the lecturer proceeds:

*Anæmic murmurs* have various synonyms: inorganic, functional, anæmic, accidental, are some of the headings under which you will find them described in the various text-books. It is not an uncommon thing at all to find a systolic murmur in a heart which is absolutely devoid of anatomical or valvular lesion, hence we term these murmurs inorganic, in contradistinction to those which result from organic change. These hæmic murmurs have certain well-defined characteristics that it will be well for us to consider.

This little girl, convalescent from scarlatina, presents us a functional murmur in its purity. As I place my ear to her præcordia, a soft, feeble, gently-blowing or softly-aspirated *systolic* murmur is heard. These murmurs are always systolic, and are never harsh, sawing, or rasping. The systolic heart-sound that accompanies these murmurs is generally clear and ringing in character; it has lost its low, booming sound, so characteristic of the normal first sound.

You may often notice these murmurs in chlorotic girls, who will then generally also present you a venous hum or murmur in the neck.

Not infrequently you may meet an hæmic murmur, during the course of acute pneumonia, puerperal fever, variola, scarlatina, pernicious anæmia, which disease is now becoming recognized in the very young, as Kjelberg records a case in a child aged five, who died one and a half months after the inception of the disease.

It is particularly in anæmic conditions that these murmurs may be recognized: the anæmia may be acute, as from sudden loss of blood by hemorrhage of a recently confined woman, or chronic anæmia due to long-standing disease, leukæmia, chlorosis, marasmus, malarial cachexia.

In cases where these murmurs are present, the heart structure has undergone change, due to a fatty metamorphosis of its muscles. This seems to apply particularly to the papillary muscles, and probably has some relation to the explanation of the physics of these murmurs.

I do not anticipate for you much trouble in the recognition of these murmurs: the general condition of the patient will assist you materially in the diagnosis, together with the character of

the murmur, which is soft and cooing, is always systolic in time, is generally heard best over base of heart, and as a rule the first cardiac sound is high-pitched and ringing. Some observers state that these murmurs are intensified by the pressure of the stethoscope. Of the truth of this statement I have never been able to satisfy myself. The course of the murmur will also aid in the diagnosis. If your treatment is successful the murmur will disappear as the patient grows better, and when the patient is finally restored to good general health, the most acute auscultor will fail to hear any bruit.

The question of treatment in these cases is always an important one, depending of course upon the cause of the anæmia, as it is solely by treating the hæmic dyscrasia that your therapeutics will meet with any measure of success..

Iron, of course, is the first drug that will occur to your mind, but let me sound a note of warning here. If you are endeavoring to remove the cardiac symptoms in a case of progressive pernicious anæmia, you will be surprised at the inutility of iron, but will be gratified with the action of arsenic in increasing doses. In the ordinary forms of anæmia, iron, the bitter tonics, liberal diet, good hygiene, change of scene and mode of living, will generally be sufficient to restore the patient to perfect health.

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### EXTRAORDINARY CASE OF PREGNANCY.

The following interesting case is from the report of the transaction of the Obst. Society of New York in the Journal of Obstetrics for November:

Dr. Schoonover (present by invitation) showed the specimen and read the following history: The patient was 36 years of age, had been married four years, and was pregnant for the second time. She was first seen by Dr. Schoonovers in January, when she complained of pain in the back and abdomen, accompanied by a slight loss of blood. From her history it was inferred that she was in the sixth month of pregnancy. A digital examination showed that the uterus was situated high up in the pelvis, the cervix being firm to the touch and the os non-patulous. The contour of the abdomen was similar to that of a normally pregnant woman. The patient ascribed her symptoms to a fall on the ice, which had occurred a few days before, and feared a miscarriage. Morphine was prescribed for the relief of the pain and rest in bed was advised. She was visited the next day, and was found engaged in performing her housework, although there was still some hemorrhage. Two months later the doctor was

called in and found the patient vomiting. There was marked tenderness over the abdomen, but no pain. The nausea was checked by five-grain doses of oxalate of cerium, and the woman was not seen again until four days later, when her attendant was summoned in haste, and thought that she was in the first stage of labor. On examination, however, the os was found to be closed, the cervix was not softened, and the uterus had not changed its position. No contractions were felt. Inferring that labor had not yet commenced, Dr. Schoonover administered morphine and waited. The patient was now seen daily and was repeatedly examined. The os remaining closed, it was dilated on April 14th, when the doctor introduced his finger with great difficulty on account of the elevation of the uterus, and felt what appeared to be a placenta previa. Two fingers were pushed through the os internum and an attempt was made to detach the supposed placenta, but neither hemorrhage nor uterine contractions followed this manipulation. The patient remained in nearly the same condition for three days, when she began to show signs of failing. She was anesthetized, and Dr. Schoonover introduced his hand into the vagina and explored the cavity of the uterus, finding it enlarged to five or six times its normal size, but perfectly empty. It was now clear that the fetus was in the abdominal cavity. Dr. Hanks was called in consultation, and it was decided to stimulate the woman (who was failing rapidly), with a view to removing her to the Woman's Hospital for operation. This was on Saturday. Her condition improved so much during the day that it was resolved to wait until Monday before transferring her to the hospital. On Sunday she began to fail again, and although she took and retained a considerable amount of nourishment, she died on Monday morning. The abdomen was opened at once and the child was delivered. The post mortem examination showed that there had been extensive peritonitis, the sac being surrounded by adhesions. It was so firmly adherent to the parietal peritoneum that it could not be separated. No evidences of a rupture could be found. The placenta was attached to the right ovary and Fallopian tube, the latter extending over it. The child was well developed, weighed about eight pounds, and had evidently been dead for upwards of a week.

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### ANTIQUARIES.

In an address before the Medical Society of Virginia, Dr. S. K. Jackson, said: "Evidently many facts which we now value were known to the ancients, having been discovered before the world was ripe for them. The comma bacillus is described in

an old work published before the close of the last century. Milk diet—our favorite at present in kidney affections—was the chief reliance of the ancients. Transfusion of blood had gone out of date in the days of Erasmus Darwin. The doctrine of germs has been traced to Harvey. Dean Swift tells of a microscopist who discovered worms in the flesh of animals. Hahnemann knew of the existence of the itch insect, for he thought it was the sole cause of all diseases. Some one has unearthed a passage from M. Terentius Maso, who lived two thousand years ago, which accounts for malarial fevers very much as we now do, and attributes them to the same cause. It is more than probable that but for the destruction of Babylon, and the burning of the Alexandrian library, we could find proof that the nations had made as great advances in the sciences as their monuments show them to have made in the arts.”

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### TREATMENT OF TYPHOID FEVER.

Dr. Arthur V. Meigs, in a chemical lecture at the Penn Hospital (*Reporter*) has the following to say in regard to the treatment of typhoid fever: “The treatment must be what we call expectant. Whiskey, if necessary, to counteract a tendency to weakness and exhaustion, eight, ten, or even twelve ounces daily, according to the urgency of the case, though it is rarely necessary to exceed eight ounces: it is as much as the stomach will comfortably tolerate. If there is any malarial complication give quinine, sixteen grains daily, in four doses of four grains each. Following the treatment just laid down by the late Prof. George B. Wood, give turpentine and dilute muriatic acid, ten drops of the oil of the former and five drops of the latter several times daily.” The specific treatment, that is to say, that based on the germ theory and germicidal action of drugs, represented by the use of tincture of iodine and carbolic acid, he has no faith in. The diet must be liquid—consisting of beef tea and milk, and as much water as the patient wishes. The attacks will last from three to six or eight weeks, and Dr. Meigs says that those who advocate the specific treatment do not claim that it will shorten the duration of the disease.

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### AN UNUSUAL CASE OF FRACTURE OF THE FOREARM.

On the 4th of September, E. M., a young man æt. 17 years, tried for the first and last time to make a car coupling. The



“bullnoses” caught the right arm just above the wrist-joint, while the “deadwoods” secured a good hold just below the elbow. I saw him about two hours after the accident. He had not yet fully recovered from the shock. The hand and arm were cold, having been for an hour or so wrapped in a towel wet with ice water. Much swelling already existed, which greatly interfered with a proper examination, but I persevered in spite of the obstacle. I found excessive mobility and crepitus just above the wrist-joint. Both bones were fractured at this point and somewhat comminuted, but just how much comminuted I was unable to determine. The flesh covering the bones was severely contused. At the junction of the middle and upper thirds of the radius and ulna the flesh was also severely contused, but the bones at this point were apparently uninjured. There was no injury to the arm whatever above. The pulsation of the radial artery was very distinct, but no pulsation of the ulnar artery could be felt. I placed the forearm in splints, and warned by the rapidity of the swelling, applied the bandages much more loosely than I usually do in such cases. Took a look at the arm three hours later, found my dressing already too tight, the arm swelling as rapidly as—I was about to say—a moistened sponge-tent. Reapplied the dressing, allowing room for any continued swelling which might occur. This was late at night. The following morning the arm presented a most unusual appearance. In point of size, it certainly would rival the arm of the fat woman at the circus. The swelling had extended upward nearly to the shoulder. I abandoned the splints, and placed the arm upon a pillow. Saw patient again at noon. Found now that the swelling included the shoulder. The swelling of the forearm had not increased any, probably because the skin could not stretch any more. The following day Dr. Hurlbut saw the case with me, and coincided with my view that the conservative plan of treatment ought to be continued, and in all probability a useful arm would result. Cloths wet with tincture of arnica and whisky had been constantly applied since placing the arm upon the pillow. In a couple of days more, large blisters, some containing possibly half a drachm of bloody serum, formed over the forearm.

On the inner side, large sloughs were forming, the outer side being *completely* covered with these blisters. The swelling now extended upon the trunk, reaching nearly to the sternum. The blisters were punctured, and large quantities of serum escaped, but there was no diminution of the swelling. Five or six days later I felt that a crisis in the case had been reached, and now, what should I do? A great portion of the inner aspect of the forearm was black, while the remaining portions of the

entire forearm presented one continuous raw sore from the bursting of these blisters.

Morphia had been given to control the pain thus far, and the whiskey and arnica cloths had been exchanged for dressings of carbolized cosmoline. I had the young man also on quinia in good-sized doses and tinctura ferri mur. The pulse was strong and 120, while the temperature was 102 to 103. The sensation of the fingers was good. The denuded surface of a portion of the outer part of the forearm had a pinkish hue, but there were spots which looked dark—almost black. The color of the hand, which was also swollen to the utmost capacity of the skin, was not very promising. The color of the skin above the elbow was none too good. Was this gangrene? Should I amputate? If so, where? At what point will the line of demarcation probably form? The case had much the appearance of a compound fractured leg which I saw many years ago. This leg was under the charge of a justly eminent surgeon, who said: "While those islands of healthy skin remain, I still have hopes of saving the limb." But the gangrenous tide would not recede, the islands were soon submerged, and five or six days later, death, with his relentless scythe, severed the last lingering hopes of the surgeon and the earthly hopes of the patient. However, there was nothing for me to do but wait. Two or three days later, I discovered on the inner and anterior aspect of the arm, above the elbow, a spot which seemed very tender and somewhat soft to the touch. Applied flaxseed poultice, and the following day plunged in the lancet. About three ounces of bloody pus escaped. Next day there was much less swelling of all the parts above this point. The tide had finally begun to ebb. The sloughs soon began to separate, and great quantities of bloody pus escaped. From this time on the case continued to improve.

The whole forearm seemed a mine of pus. I promptly opened the abscesses as rapidly as they formed. In about seven weeks I found that union of the fractured bones had taken place. The size of the wrist was enormous, owing to the great amount of callus thrown out. The shoulder and elbow were all right, wrist joint stiff, fingers benumbed and nearly motionless. Pronation and supination were also lost. The abscesses were still discharging large quantities of pus. Massage was soon begun, and also passive motion. At the end of six months the discharge of pus had finally ceased. The proper motions of the wrist joint had been restored, as had also pronation and supination. The arm seemed quite straight, the callus had been absorbed until the wrist was no larger than it should be. The fingers and thumb could all be bent, but not voluntarily. The thumb and

first two fingers seemed to be partially paralyzed; the others were all right. Massage was continued.

Now, at the end of a year, the arm is weaker than the other, and there is some little atrophy of the muscles of the forearm. The motions of the thumb and first two fingers are still somewhat impaired, but the trouble seems to be at the extremities only. The grip with the whole hand is good. He has been working for two or three months.

What made this great swelling? Why was there so much pus discharged? I think that a blood-vessel was ruptured, and as there is no pulsation of the ulnar artery now, I think here lies the secret.—*Walter H. Parcells, M. D., in Medical and Surgical Reporter.*

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## THE OPERATIVE TREATMENT OF ACUTE INTES- TINAL OBSTURCTION.

Read in the Section of Surgery at the meeting of the British Medical Association in Cardiff, by  
J. Greig Smith, M.A., F.R.S.E.

In regard to the general principles which ought to guide us in the operative treatment of intestinal obstruction, I am in full and hearty accord with Mr. Treves. I think the time has come when laparotomy for this malady may no longer have to struggle against the ban of being considered as a forlorn hope, but may be elevated to the dignity of a plan of treatment. Medicinal treatment too often is aimed, not at the disease but at the diagnosis; forgetting that, while drugs are obscuring our vision, the disease is killing our patient. We must not forget that a patient with acute intestinal obstruction is as gravely ill as if he were bleeding from a large artery, and that, though the disease is not so palpable, and perhaps not so rapidly fatal, it is one requiring an attention just as close and continuous, and a treatment even more decided and skilful.

On these broad principles, so well put before us by Mr. Treves, I have nothing new to say. I desire to occupy the time at my disposal by specially considering two points in the operative proceeding on which I am at variance with Mr. Treves, as well as with other surgeons.

The first point refers to the usual method of finding the cause of obstruction: the second to the treatment of the bowel after the obstructing cause has been removed. I may state them as propositions.

1. The best guide to the seat of obstruction is not manual exploration, but visual examination, assisted, if necessary, by extrusion of the bowel.

11. No cause of operation for intestinal obstruction is properly concluded until overdistended bowels are relieved of their contents.

1. You are all familiar with the rules laid down for our guidance in seeking for the site of intestinal obstruction. We are to explore the common sites—the cæcum, the promontory of the sacrum, or the umbilicus, we are to seek for collapsed bowel, and follow it up until we come to dilated bowel. And this we are to do with the hand inserted in the abdominal cavity through the opening we have made.

Let us suppose that the cæcum is distended; we expect that the obstruction is in the colon below it, and we are told to follow up the colon until we meet with it. The incision is in the middle line, below the umbilicus. The abdomen is distended, its walls are tense, and the transverse colon is probably pushed high up under the ribs. Through this opening, therefore, we must insert the hand, push it over the distended coils, perhaps as far as the elbow, and isolate and diagnose the condition of the colon through its course. Easy as this looks upon paper, I would consider it in practice as one of the most difficult undertakings in surgery. If those of you who have not tried it in practice will try it several times in the *post mortem* room, I think you will agree with me.

Looking for the constriction by exploring in other ways is only a little less difficult. If the hand, on insertion, were not met and surrounded by a bewildering labyrinth of dilated bowel that will stick to the skin, and will not give up following it; if the ordinary sites of obstruction were open to vision or to touch; if the intestinal walls were only a little more definitely palpable, and a good deal less dilated, then exploration would easily and surely lead us to the obstructing cause. But the conditions are all against the exploring hand, and I am in favor of another method,

The abdomen being opened, the presenting bowel is keenly observed. The most dilated portion of the bowel rises nearest the surface, and the chances are strongly in favor of its being near the abdominal opening. Move the coils upwards and downwards, to the right and to the left, and fix upon the most dilated or the most congested portion. Use this portion as a guide, running the forefinger along its mesentery; it will probably guide us to the seat of constriction. If this most dilated piece of the gut be with difficulty detained inside the cavity, let it escape; it wants further treatment; and if we have not already discovered the obstructing cause, its escape and the manner in which it comes out will help us to find the cause. At the site of obstruction, and near it, the bowel is fixed, and this portion will not readily be extruded at this end of the loop, for, as we do so, in-



creasing congestion and distension will tell us that we come nearer and nearer to the obstruction, until, in a comparatively short time, we are certain to reach it.

I may say at once that, even if we can diagnose obstructions in the colon through the ordinary laparotomy incision, we cannot treat them by this incision. Obstruction in the colon is nearly always diagnosed as such before operation, and is treated by colotomy, lumbar or genital. As far as I know, median laparotomy has, in the large majority of cases, had to be supplemented either by a transverse or a lumbar incision where removal of a growth or relief of an obstruction in the colon has been attempted by the operation. It is, therefore, something only a little less than a surgical catastrophe if we perform median laparotomy for obstruction in the colon. This somewhat diminishes the value of our discovery of a dilated cæcum in such cases.

I would, therefore, substitute the finger for the hand, and supplement both by the sight; I would in the first instance at least, ignore the cæcum; I would permit the bowel to extrude if it were much extended; I would even encourage it to do so, if I had not at once discovered the seat of obstruction, and its extrusion were any help to me in this discovery; and I would go through all this before I inserted my hand to grope for the cause.

I cannot understand the universal condemnation of extrusion of the gut in these cases. Surely it is a remnant of the pre-abdominal era of surgery, when exposure of the peritoneum was considered as a calamity, and extrusion of the bowel as almost certain death. We handle the bowel freely enough in other abdominal cases. We strip it from adhesions, tear it and stitch it up; cleanse it of inflammatory and extravasated material, and handle it in every conceivable way without harm. Why should the simple escape of it from the abdominal cavity alarm us so in intestinal obstruction? If we protect it properly with flat carbolized sponges it will come to no harm; if we decide to return it intact, we can do so readily enough after emptying it by compression between the hands, and so forcing its contents into the general abdominal cavity. But, in most cases, I think we ought to empty it before returning it; and this brings me to the next proposition.

II. No operation for intestinal obstruction is completed that leaves the abdominal cavity full of overdistended bowels. In every case where intestinal distension is a feature of obstruction, I believe that the intestines ought to be relieved of their contents; or, if this cannot be done with sufficient ease or rapidity, that an artificial anus ought to be made, and closed after the dangerous symptoms have passed.

When we have found and removed the primary cause of obstruction, we are apt to believe that we have done as much as our art tells us we can do for the cure of the patient. I believe this is very far from being the case. Large quantities of fluid lying in intestines paralyzed from overdistension and inflammation may be a cause of obstruction, as efficient and as dangerous as strangulation by a band. The condition is, in fact, similar to or almost identical with that found in the class of obstruction known as physiological, and is, as being complicated with laparotomy, even more dangerous.

Some aid to our understanding of the physics of this condition may be got from simple experiments in the *post mortem* room. If, before the abdomen is fully opened, it be sought to fill the intestines with fluid through an opening in the duodenum, it will be found that a very considerable amount of pressure is required to do so: that in most cases the abdomen will be fully distended before the fluid has passed half-way down ileum: and that, if the abdomen be fully opened, and the intestines permitted to extrude, many ruptures of their peritoneal covering will have taken place before the fluid escapes from the anus. If, now, the mesentery be cut through at its root, and the bowels laid on the table open at both ends and free to empty themselves, only a little fluid will escape, and the mass of fluid will remain imprisoned. The cause of this is easily seen to be the acute flexures of the bowels, brought about partly by their being confined inside a close cavity, and partly by their attachment to the mesentery. These acute flexures of the intestinal tube upon itself, forcing in the mesenteric side as a sort of valve, cause an obstruction to the lumen, which, repeated over three or four bends, is practically insuperable by the force at command. And these forces are of the feeblest. An overdistended bowel, like an overdistended bladder, is already half paralyzed: and if to this be superadded the paralysis arising from inflammation, we can appreciate the weakness of the force which has overcome the by no means insuperable obstacle. The small amount of good that follows tapping a distended bowel with a fine trocar is thus explained; the gut is emptied down to the first or second flexure, and that is all. We may reasonably conclude, therefore, that the presence of an excess of intestinal contents is in itself a cause of obstruction.

Various approved modes of treatment lend support to this view. I would refer to the high value which for centuries was placed upon emetics in the treatment of this complaint, by the most skilled practitioners. Quite recently Kussmaul, by an emesis which is purely mechanical, and not medicinal, has revived this treatment with a gratifying measure of success. By repeated applications of the stomach-pump, he empties the loaded

intestines of their gas and fluids, always to the relief of the symptoms, and not unfrequently to the cure of the disease. Vomiting always relieves the patient, and, if this theory be right, ought to be encouraged. It is one of the evils of opium that it diminishes the contractility of the intestinal fibre, prevents vomiting, and permits this deleterious accumulation of fluid and gas in the intestines. If opium is less dangerous than croton-oil, I am by no means certain that sulphate of zinc is not less harmful than either.

In support of my thesis, I would place most weight on the acknowledged value and increasing reputation of Nelaton's operation of enterotomy, as it might be called. It is a fact of extraordinary significance, that mere drainage of the intestinal contents in any and every form of intestinal obstruction should be frequently successful in saving life, and even in curing disease. For almost every form of obstruction, enterotomy is applicable; and in nearly every form it has had success. The obstruction may not have been relieved, the strangulation may not have been reduced; all that is done is to give the intestinal contents free exit at any point that may be convenient; and this alone may save the patient's life. Kussmaul's treatment goes to show that discharge of intestinal contents by the upper extremity of the bowel is beneficial. Nelaton's operation has with much greater frequency shown that discharge through a low opening is beneficial. If to these practical facts we add the theoretical considerations I have advanced, it seems to me that a strong case is made out in favor of relief of overdilated bowels. If this can be satisfactorily done by incision and immediate suturing, all the better, if not, I think it is our duty to establish for a short time an artificial anus.

Upon the details of the operation itself, the time at my disposal does not permit me to speak. Though, as operator or as chief assistant, I have been concerned in only nine cases of laparotomy for acute intestinal obstruction, I have seen enough to make me certain that the operation is one of the most delicate and difficult in the whole range of surgery; that it demands a combination of dexterity in manipulation, of sensitiveness in touch, of rapidity and decision in thought and action, such as accurate knowledge and practical culture alone can give. In the future, an increasing number of these cases will be handed over to us by physicians; it behooves us, as surgeons, by every means in our power to prove ourselves worthy of the trust.—*British Medical Journal*.

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## THE INFLUENCE OF DRUGS ON MILK.

In a medico-legal case MM. Brouardel and Pouchet were asked whether an infant of two months could have been poisoned fatally through its mother's milk, the mother having been for some time under treatment with arsenic, and on several occasions having shown symptoms of arsenical poisoning.

To settle the point, M. Brouardel made a number of experiments by giving Fowler's solution to nursing women, the result of which showed that arsenic can readily be found in the milk even when taken in small doses, but that no toxic symptoms are likely to be produced in the child, unless the mother be taking a toxic dose.

Fehling has lately experimented upon the subject of the elimination of drugs by the milk, and found that salicylate of soda, iodide of potash and iodoform can all be traced to the urine of the nursling, the latter drug when taken in very small quantities and even when applied externally. Hence he advises against its use as a dressing for wounds in nursing women. He has also found corrosive sublimate in the urine of children whose nurses had the drug applied externally, but the quantity passing to the child was so small, that he thinks it unnecessary to use the same precautions with corrosive sublimate as with iodoform.

The narcotic substances are without effect upon the nursing. The largest doses of opium or chloral administered to the nurse do not bring about any especial symptoms in the child.

Atropine was tried on animals and no dilation of the pupil or other manifestations occur in the suckling, excepting when the maximum therapeutic dose has been exceeded.

Fehling therefore comes to the conclusion that while but few drugs administered to the mother prove deleterious to the infant, a strong exception, however, should be made of those substances that are eliminated with difficulty and accumulate in the organism.

Nevertheless it is certain that many substances when ingested produce decided effects upon the milk. "Milk sickness," or "the trembles," occurs in persons using the milk of cows which have fed on certain pasturage, and the odor of copaiba or asparagus can be detected in the child's urine when these substances have been taken by the nurse; moreover, artichokes, absinthe and other substances will make the milk bitter.—*Northwestern Lancet*.

## THE BROMIDES IN INFANTILE THERAPEUTICS.

Especial reference is made to the use of the bromide of potassium, the other salts being less frequently used. Accord-



ing to the age of the patient, it should be given as follows: To a child under one year of age, about three grains daily, in two portions; to a child under two years of age, about six grains, in two portions; in either case being given as a powder or syrup, and always well diluted with a suitable liquid. To children over two years of age, it should be given in 15, 30, and 45 grain doses, until it produces its physiological effect. In some cases the dose should be a fixed one, in others, the quantity should be gradually increased during five or ten days, then diminished until it is given up altogether. In epilepsy, the doses should be gradually increased until the limit of tolerance is reached, the treatment being kept up for a long time, and very gradually discontinued. The iodide and bromide of potassium combined are frequently indicated in the treatment of epileptiform attacks, symptomatic of cerebral lesions. Simon advises only the bromide in the cases of cephalalgia and irritable heart, which occur so often during the period of rapid growth in youth. It must always be remembered in giving the bromides for a long period, or in very large doses, that there is danger of exciting an irritation of the gastric mucous membrane, and perhaps of producing an intense gastralgia.—*Arch. of Pediatrics.*

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## THE RELATIONS BETWEEN PHYSICIANS AND THEIR PATIENTS.

Nothing has worked more harm, both to physicians and their patients, than the latter's crude ideas of disease and their consequent treatment of the former.

The practice of medicine is very old; it long antedates any true knowledge of disease; but ills did not call less loudly for relief because they were not understood, and these calls were not made in vain. This practice, prior to the knowledge of disease, however, was not always without reason and method; in those days they had two ways of proceeding: (1) by specifics, and at a much later date (2) by symptomatic treatment. In the beginning, all recognized diseases had their names and specifics, later the more observant began to notice ills that could not be included in the list of diseases known, and having no specifics for them commenced to treat them symptomatically; success gradually made them sceptical of their former specifics until none of the original remained, and since men can be said to have really acquired some knowledge of disease, very few have been added in their places.

It naturally follows that the laity not being possessed of this knowledge, their idea of treatment is the use of specifics; and

they think it strange that all these centuries of study and experience have resulted in the rejection of the former host of specifics and the replacing of them by scarce a corporal's guard in number.

To them, disease is a something entirely distinct from the body which ought to be neutralized or driven out immediately, should the physician understand his business. They are unwilling to believe that organs which have gradually become diseased can at best only gradually recover, and that with the self-limited diseases which have no antidote, the doctor who ably seconds nature in its struggle deserves far more credit and recompense than if he had possessed a specific. As an example, the treatment of malarial fever, before the introduction of quinine, required much more skill and attention than at present.

That this craving for specifics among the laity is taken advantage of by unscrupulous men, may be seen by taking up any daily newspaper and glancing through its columns. These men are sharp enough to propound questions to the would-be sick, that soon convince them they are on the verge of dissolution and can only be saved by taking the medicine in question.

We have, also, travelling quacks who always promise cures, in fact guarantee them, but always exact part payment in advance: it is true they hardly ever get the second payment when they have any real disease to handle, but they make the first payment large enough to pay them. For a working rule, we would say that a man's honesty or ability is in the inverse ratio of the number of specifics he vaunts.

There is no doubt that the pathies, which flourish in this country, have some good in them. It is not that the baths of the hydropaths do not benefit some troubles. The fault we find is that they are recommended for the cure of all diseases. In fact, the cry of all pathies is *cure*, and it is as attractive to the general public as the music of the pied piper was to the rats and children of Hamelin town, and the results, we think, often as disastrous to the victims.

Though there are few diseases which are susceptible of cure, there is an immense number the course of which the physician can check and ease, or even in certain cases completely arrest.

In febrile, diseases, also, timely aid may enable an exhausted vitality to tide over the crisis, and thus a true physician may be said to be the companion who helps his patients fight their battles, and not the magician who annihilates their enemy. They must regard him as one, human like themselves (even to the appreciation of money), who has spent the best part of his life in laborious studies, in order to be able to shield them from the results of those inroads he is powerless to prevent.

In choosing a physician they must remember that they are

choosing one to whom their life may at any time be entrusted and they must make the choice seriously, but when once made, implicit confidence should be given, for no layman is the competent judge of the treatment of a case, and no physician can do full justice to his patient unless he feels he has his confidence.—*New Orleans Medical Journal*.

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### ON DIETETIC ERRORS IN FEEDING INFANTS.

In view of the absolute and relative increase in the number of children affected with rachitis, within the last ten years, the supposition is warrantable, says the editor, that the various artificial foods, with which the market is flooded, are deficient as a substitute for mother's milk, or else that their mode of exhibition is at fault. Especially during the first four to six weeks of life should artificial foods be avoided, since the pancreas does not begin to secrete its diastatic ferment until after the first month. Hullmann, of Halle, has recently written an important paper, covering the subject of artificial foods, and his opinion is that the objection to them is due to the improper manner in which they are exhibited. The conclusions of his paper are:

1. Mother's milk is the only perfect food for the infant.
  2. The infant ought not to be fed artificially during the first four to six weeks.
  3. Cow's milk is the best substitute for mother's milk.
  4. The quality, quantity, and mode of ingestion of food stuffs ought to be equally considered.
  5. Diarrhœa in children must be regarded as a grave affection.—*Therapeutic Gazette*.
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### CREASOTE WATER AS A LOCAL ANÆSTHETIC.

The officinal aqua creasoti, or creasote water, is so important as a preparation for one special use that it is well to notice it in order to emphasize that special use. It is a simple 1 per cent. solution of wood creasote in water, and, like similar solutions of carbolic acid and of cresol, it is a most effective local anæsthetic, and topical dressing to burns and scalds. It is no better than the solutions of carbolic acid, or of coal-tar creasote, for this purpose, but it is quite as good, so that whichever is most accessible or most convenient may be used. This creasote water, as made by the above formula—or diluted with an equal volume of water, or with more water for delicate surfaces in women and children—and applied by means of a single thickness of thin muslin, or worn—

out cotton or linen, such as handker stuff, and the application renewed from time to time, as the return of pain requires it—will relieve the pain of burns and scalds in five to ten minutes, and will retain the relief as long as the applications are properly renewed, or until the painful stage is over.

It is also very effective as a local anæsthetic for general use in all painful conditions of the surface only, such as the pain of erysipelas. The benumbing effect of these phenols upon the skin is very promptly reached, and can be carried to almost any degree that is desirable by simple management of the strengths of the solutions and the mode of application. They are true anæsthetics to the skin, while the much-lauded cocaine is not.

This statement has been published so often during the past twenty years, and the treatment has been so effective in so many hands, that it is wonderful to notice how the common practice is still to us the old and comparatively useless hot dressings, such as carron oil, white lead ground in oil, flour, liniments, etc., or the newer application of solution of carbonate of sodium.—*Medical News*.

### PROF. DA COSTA'S CLINIC.

I. On September 28th, a boy, aged thirteen, presented himself for supposed ascites. Abdomen much swollen; came on suddenly; has had malarial fever; no swelling of feet: is constipated at times; tongue somewhat coated. On examination, spleen is found to be not markedly enlarged; no fluctuation of abdomen, but on percussion, a markedly resonant note is heard.

*Diagnosis*—Flatulency, due to atony of the bowel.

*Treatment*—Strychnine,  $\frac{1}{80}$  grain three times a day, and  $\frac{1}{10}$  grain aloin each night. On October 5th, the boy came back entirely recovered.

II. Boy, aged twelve, complains of vomiting, pain in the head and vertigo, which he has had for several months. He describes the pain as jumping: it is in the temples and back of the head, and periodical: pupils large and react sluggishly: there has been no loss of flesh: no history of a blow or injury to head: pulse rather rapid, not quite regular: tongue quite clean. Vomiting takes place without regard to meals; urine normal: no evidence of any hereditary taint, teeth not notched: no ptosis: on ophthalmoscopic examination, both optic nerves are found to be swollen, œdematous, and the arteries and veins enlarged and tortuous (choked disks). He suffers with convulsions; sight is failing.



*Diagnosis*—Intracranial pressure from a tumor toward the base. Inherited syphilis the most probable cause.

*Treatment*—Bichloride of mercury,  $\frac{1}{32}$  grain ter die, slowly increased to  $\frac{1}{16}$  grain. A bland, easily digested diet.

III. Man, aged thirty-four; was well until a year ago last April, when he began to have pains in legs and thighs, with a tired feeling; soon began to lose power of locomotion, until last February it was almost entirely gone; no history of blow, accident, or of syphilis: uses tobacco but no liquor; generally free from headache. Eyesight and hearing have been poor since he had scarlet fever: taste keen: tongue clean, slightly fissured; pulse 96: no heart lesion, although an anæmic murmur is heard: never had rheumatism: muscles are much dwindled, and show fibrillar contraction on being struck on arms, chest and back. He was a hard laborer: grasp very feeble: tendon reflex good: cannot walk without assistance, and then the feet are not raised much from the ground: sensation unimpaired: electro-muscular contractility well preserved: can stand with feet close together: appetite and digestion good: bowels constipated; no attacks of giddiness; no spinal tenderness.

*Diagnosis*—Progressive muscular atrophy.

*Prognosis*—He will improve, but will not recover.

*Treatment* The best treatment is that which keeps in mind the muscles. Massage, friction, electricity, with  $\frac{1}{60}$  grain of strychnia ter die.—*Col. and Clin. Record.*

## PRECURSORS OF BRAIN DISEASE.

The precedent of all grave cerebral disease is neuratrophia, or defective nerve nutrition. Neuratrophia may, in a sense, be considered as functional, to distinguish it from organic disease; *i. e.*, it may be so slightly organic as to not necessarily excite alarm for such seriously destructive change as tends to a speedy and grave destruction of physiological function.

The essential psychical symptoms of general functional neuratrophia, which are precursory of brain break down, and which by long continuance, unrelieved by curative treatment, so often ultimate in destructive conditions, are now to engage our attention.

Impending brain failure is seldom manifest on the psychical side—indeed, I doubt if it ever is—without some mental changes. The bold business man becomes timid and overcautious, or the discreet man becomes indiscreet and somewhat reckless in his business transactions without adequate appreciable cause.

Timidity unnatural to the individual, a shrinking from un-

dertakings which, in better states of brain tonicity, would have been entered upon with reasonable confidence and courage, is a sign of more value than has been attributed to it.

Unnatural timidity, irresolution, and fear, should always engage our attention, and the victims of them should have our advice long before any particular organ of the system fails. This is the most important fact for the general practitioner to consider.

A recuperative therapy should be advised in rest, recreation, and change of mental occupation and environment. These morbid fears, and the irresolution and timidity which underlie them, are but the shadows (if unaverted) cast before the graver coming events in the accepted symptoms of insanity. Neuratrophia underlies almost all insanity.—*C. H. Hughes, M.D., in Kansas City Med. Record.*

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### SALICYLIC ACID AND CASTOR OIL IN PSORIASIS.

Dr. Fox, of New York, showed at a meeting of the New York Dermatological Society a girl eight years old who had psoriasis covering all the body. The patient's father and sister also had psoriasis. When she was admitted to the hospital, a 2 per cent. solution of salicylic acid in castor oil was applied to the right arm, a weak solution being used because of the great congestion of the skin. When the patient was shown the scaling was less, and many of the patches had disappeared, although the disease was spreading in other directions. To the left arm the mixture of oxide of zinc and balsam of Peru had been applied, and there was even less congestion in this situation. In the second case, the lower extremities were chiefly affected. This patient was peculiarly susceptible to the action of ammoniated mercurial ointment, even in a very small quantity exciting severe dermatitis. Chrysarobin pigment had been applied to the right leg, and a 5 per cent. solution of salicylic acid to the left leg, producing a marked improvement in the condition of the eruption in the latter situation.—*Journal of Cutaneous and Venereal Diseases.*

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### CANCER OF THE UTERUS.

The following is taken from a clinical lecture by William Goodell, M.D., published in the *Medical Bulletin*, August, 1885. The patient was thirty-nine years of age, had had five children, the youngest eleven years of age.

There are three forms of cancer which may attack the uterus: scirrhus, epithelioma, and encephaloid, but there is no

doubt that they merge one into the other. The practical question is not so much, is the tumor scirrhus, epithelioma, or encephaloid cancer, as it is a question whether or not the growth is malignant. There is only one thing about this differentiation, and that is that epithelioma is more amenable to treatment than either of the other forms. In the vast majority of cases, when cancer attacks the uterus it takes the form of epithelioma. There are some cases which seem to begin as scirrhus, and ultimately break down into the epithelial form.

There are certain popular fallacies about cancer of the uterus. One is that it is always accompanied with pain. Carcinoma of the neck of the womb does not always produce more pain than most women experience at each period. It is only when the disease advances toward the internal os that pain is felt. When it ascends and invades the cavity of the womb the woman's sufferings are very great. You see in our practice in the dispensary the same thing. We hook tenacula into the cervix and apply powerful caustics without eliciting any sign of pain. Under some circumstances, just as cartilage, which is normally insensible, may become excessively tender, so the cervix of the womb will, under certain circumstances, become very sensitive, and the slightest touch will cause the patient to flinch: but, as a rule, in cancer limited to the neck of the womb there is no pain. There may be leucorrhœa, and that will certainly be if there is an open sore. This is a very common delusion. Old physicians have said to me, "O no, doctor, it cannot be a cancer, there has been no pain." The idea of cancer is associated in their minds with lancinating pain, which cuts like a knife. When carcinoma invades external portions of the body which are well supplied with nerves, these pains are present. The sensitive portion of the womb begins at the internal os, and the lining membrane is very sensitive.

Another fallacy is, that there is, in every instance, the cancerous cachexia. This is a great mistake. My impression is that one-half of the cases which come to me do not present the cancerous cachexia. Instead of being lean, bony, and scrawny, with the leaden hue of the countenance, many of these cases present a buxom appearance, with rosy cheeks. It is my experience that such cases are less amenable to treatment, and operation is less liable to be followed by temporary benefit, than in those cases which present the appearance of the patient before us. In our patient, if the disease were limited to the cervix, I should expect that the operation would do a great deal of good.

Again, cancer may exist without bleeding. Before ulceration occurs it is not present, and even in the vegetating form it may be absent, although there is usually some discharge. This

discharge need not be offensive, and this is another point which it is well to bear in mind.

I wish now to give you a little history of this case. She comes from a distance, and was brought here by her husband in great distress of mind. She had been told that she had a cancer. My own rule, to which exceptions are very rare, is never to tell a woman that she has a cancer. I speak of it as a bad ulceration. Many of my patients have known in their hearts that they have a cancer, and know that I know it, and yet the word "cancer" never passes our lips. Many women say to me, "Now, Doctor, if I have a cancer, do not tell me." I advise you to adopt the rule which I follow. I do not want you to lie about it, but never tell a woman that she has a cancer if you can get out of it.

This woman came in a very painful state of mind. As a drowning man will grasp a straw, so she was willing to embrace anything that would do her good. She tells me that she has five children and can not bear to think of leaving them. I said to her, "While I cannot cure you, I may be able to do something which will do you a great deal of good." She jumped at the idea, and I have not disillusionized her. She thinks that I am going to do more than I can do.

When I examined her, I found a great excavation. What I thought of doing was to scrape off the vegetations, and if I dared, cover the part with nitric acid, but a symptom has appeared which shows that the disease has attacked the bladder, and I can do nothing for her. Three days ago she began to pass blood from the bladder. The urine does not trickle into the vagina, because there is no opening as yet, but the disease has involved the bladder, and in the course of a few days the tissue will break down, and there will be produced a vesico-vaginal fistula, through which the urine will trickle into the vagina.

There is still one other thing. That woman has not long to live. Her sufferings will, I think, be excruciating. She ought to have as much opium or morphia as will make her comfortable. Some would object to this, saying that she would get into the opium habit. She will not live long enough to contract the habit. I say let us make the last end of her life as comfortable and peaceful as we can. Give her opium in any form or amount that she chooses to take it, exercising a little restriction in the beginning.—*Med. Journal.*

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### GONORRHŒAL RHEUMATISM.

The following is taken from a report of the discussion of the above subject before the Cincinnati Academy of Medicine in the *Lancet and Clinic* for November:



Dr. Thrasher thought that the essayist and authorities quoted by him had adhered too closely to the doctrines of *post hoc, ergo propter hoc*. So many individuals suffer from gonorrhœa that it is not wonderful that some of them should have rheumatism, or repeated attacks of rheumatism coincident with the gonorrhœa. But the rheumatic attacks are so varying that the true rheumatism may frequently be confounded with other arthritic affections. The several ingenious methods of reasoning as to the connection between gonorrhœa and rheumatism seem extremely fallacious. The most ingenious is probably the neuro-pathic theory, but it is difficult to see how irritation of the extremity of a nerve should occasion a reflex pain in one certain joint and not in others. The same objection may be raised as to the pyæmia theory. It is exceedingly improbable that in migration the gonococcus should stop at one joint and not at others, or why it should not in its passage lodge in the liver, lungs, brain or other parts of the body which it traverses.

Nothing is better known than that true rheumatism will repeatedly attack the same joint.

We might, indeed, rather account for the gonorrhœa as caused by the rheumatism, than *vice versa*. We know that gleet can be readily changed into a gonorrhœa again by an irritating condition of the urine. The acid condition of the urine in rheumatism may come on before the febrile symptoms of the rheumatic manifestations, and by thus causing a recurrence of the gonorrhœa, support the theory of the existence of a gonorrhœal rheumatism.

Among the number of examinations of the joint exudations in so-called cases of gonorrhœal rheumatism, in but one was the gonococcus found. Even the best microscopists makes mistakes, and even admitting that the gonococcus is the cause of gonorrhœa, it would have to be discovered in many more cases before it could be accepted as the cause of the accompanying rheumatism.

In the case reported the rheumatism came on after the gonorrhœa had been present for fourteen or fifteen days. The patient's health by this time was certainly considerably impaired and it is in just such debilitated states of the system that rheumatic affections limited to one joint are most apt to come on. In this sense there might be some relation between gonorrhœa and the ensuing rheumatism—not as a direct but only as a predisposing cause.

Dr. Ravogli did not admit that rheumatism could be caused by gonorrhœa. Until now it has not been established whether gonorrhœa was a specific affection or not, whether it was due to a virus or not. If we review the history of gonorrhœa we find that Swediaur injected his urethra with caustic ammonia. A

urethritis, with all the symptoms of a gonorrhea, followed and lasted six to eight weeks. Handel reports the case of a young man who used as an injection a solution of caustic potassa. A urethritis with all the characteristics of an ordinary gonorrhœa resulted. On the 16th day he had connection with a woman, who, in turn, was attacked with a typical case of vaginitis blennorrhagica. Ricord would not admit gonorrhœa to be specific until demonstrated that something existed in the chemical or physical characteristics of the pus to substantiate the view. Rollet, who was exceedingly opposed to the doctrines of Ricord, in speaking of the specificity of blennorrhagia, says that it would be a great presumption on the part of a physician to state whether an attack was specific or not. Many cases are reported of women having a simple leucorrhea who do not infect their husbands, yet if cohabiting with another man will infect him. This may be explained by a kind of acclimatization.

Elkunod, of Stockholm, demonstrated the gonococcus to be identical with a micrococcus occurring in stomatitis ulcerosa and some diseases of the stomach and intestines. If this be true, then certainly the so-called gonococcus cannot be considered the specific cause of gonorrhœa. Blennorrhagia is nothing but a localized disease of the urethra or of another mucous membrane with which the pus of blennorrhagia may come in contact.

Prof. Gruben spoke of the contagiousness of the purulent secretion of the Eustachian tube, which may be carried from one side to the other. It seems that in the secretions of the mucous membranes there is something which has the property of reproducing the same process in another mucous membrane. We know also that pus exposed to the air is capable of taking some irritating properties, as is shown in the purulent discharge from the ear causing an eczema of the ear and face. Thus we find about the genitalia of a woman with blennorrhagia an eczema, and hence it is not to be wondered at, that when this irritating substance comes in contact with the male urethra an inflammation results. If the pus of blennorrhagia possesses some specific property it would necessarily at any time produce an acute inflammation, but when taken at the end of an attack when but few pus corpuscles remain, it will produce only a slight affection. Blennorrhagia, except in its severer forms, is rarely attended by fever. In his extensive hospital experience of venereal diseases, the speaker had never met with a case of rheumatism due to blennorrhagia. In but one case urethritis attended an attack of gonorrhœa. It was located in the foot, and probably due to an injury or to the occupation of the man. He frequently attended this man for the same affection of the same part, and would consider the simultaneous appearance of gonorrhea and urethritis a

simple coincidence. The speaker remembered the case of a man who was confined to his bed every five or six months with an attack of rheumatism, and at such times in consequence of the uric acid an irritation of the urethra resulted. We have arthritis occurring in scarlet fever and measles, which are essentially virulent diseases.

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### PREPARATIONS OF GLYCERINE.

The *British Pharmacopœia* contains five preparations of glycerine, all of which are useful and convenient; some of them are used externally, some internally, and some applicable in both ways. "Glycerine of carbolic acid," "glycerine of tannic acid," and "glycerine of gallic acid," each contain one part of their respective acids in four and a half parts of glycerine. "Glycerine of borax" contains a like proportion of borax. "Glycerine of starch" contains one part of starch in eight and a half parts of glycerine. The *United States Pharmacopœia* also contains these preparations (excepting the last one): but their proportions and formulæ are somewhat different. We also have an official "glycerine of tar." Our term "glyceritum," or "glycerate," is preferable to the English "glycerine."

*Glycerine of carbolic acid*, in doses ranging from five to ten minims, suitably diluted, is serviceable in scarlet fever, measles, and small-pox; and by lowering the pulse and inducing perspiration, it has a beneficial effect in fever. Many forms of diarrhœa, vomiting and dyspepsia yield to it; and it often times promotes the expulsion of intestinal worms. It may be used as a gargle, well diluted, in sore throat with fœtid breath, and, mixed with an equal bulk of water, is painted on the tonsils and fauces in diphtheria. One drachm in an ounce of water form an excellent lotion for eczema, lepra, carbuncles, syphilitic ulcers, etc. Undiluted, it is employed in small-pox, to prevent the "pitting," and is useful in ringworm, scabies, and other parasitic diseases.

*Glycerine of gallic acid* may be taken internally in ten to sixty minims, diluted, as a general astringent, in the night sweats of phthisis, in pyrosis, and in albuminuria. It is one of the best agents for the arrest of hemorrhage from the kidneys, uterus, or bladder; and for all cases where the bleeding vessels have to be reached through the circulation. For external use, it is inferior to glycerine of tannic acid.

*Glycerine of tannic acid* may be taken internally in doses of ten to forty minims, for the same purposes as glycerine of gallic acid, but it is generally less efficient. Externally, it is more useful than gallic acid, and is a good paint for relaxed uvula, chronic tonsillitis, and many throat affections, and is beneficial in ozæna,



chronic otorrhœa, hay fever, and coryza. It also makes an admirable injection, well diluted, for gonorrhœa (male and female) urethritis, and gleet.

*Glycerine of borax*, from half a drachm to two drachms, diluted, is refrigerant and diuretic. It has an acid reaction. It causes contraction of the uterus, and, sometimes, abortion. Combined with ergot, it assists the expulsion of the placenta. It is useful as an emmenagogue. Half an ounce of glycerine of borax in four ounces of water act as an aphrodisiac, when used as an enema. Externally, it has many uses in skin diseases, notably in chloasma, or pityriasis versicolor, which it cures by dissolving the epidermis. It is used for chilblains, chapped hands, fissured tongue, apthæ, and cracked nipples, applied as an undiluted paint, and is valuable in pruritus pudendi, and sometimes in diphtheria.\*

*Glycerine of starch* is employed externally for excoriations, etc., and is a useful article in the nursery.—*Med. World*.

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## POST-PARTUM HEMORRHAGE.

Last year I had the honor to present to this society a paper on Post-Partum Hemorrhage, which excited an earnest and protracted debate—that I am fain to do some good—by bringing up to our professional vision with great distinctness two very important points in obstetrical practice, viz.: that there are certain principles underlying the scientific management of post-partum hemorrhage, and that he only is a competent and safe obstetrician who, in advance of meeting with a case of this hemorrhage, is thoroughly conversant with these principles, it being manifest that after the advent of the hemorrhage there is no time to hunt up the proper practice nor send for counsel. Whatever is necessary to save the patient must be done at once. A delay to do the right thing for even a few minutes may be fatal to the patient, and to do the wrong thing promptly or deliberately may be equally disastrous.

It is these considerations that give me warrant to present the subject afresh at the first opportunity; and, furthermore, the diverse views of the proper management of these cases proclaimed by the polemics last year seem to make it judicious to keep the subject agitated until our professional minds arrive at something approaching unanimity as to the best line of procedure, or otherwise establish the fact that several lines are equally feasible and reliable.

My position last year was that the dogma, so earnestly pro-

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\*Salicylic acid dissolves readily in water, by the addition of four times its quantity of glycerine of borax.



mulgated by the late Prof. Meigs in these cases, "Turn out that clot," was surely not a safe rule of action in all cases, and possibly applicable to only a small minority of them, and after the interchange of sentiment and experience by the members on that occasion I was confirmed in that position.

Although it was not distinctly stated in my former essay, that it was never necessary to insert the hand into the uterus for the sole purpose of clearing it of the clots of hemorrhage after childbirth, such an inference was a fair conclusion from the tenor of the article, and I felt justified in the idea from the fact that in over forty years of general practice, with a full proportion of obstetrical engagements, I had never met with such a necessity. The one condition that would theoretically demand such an interference is when the uterus is filled with blood and the hemorrhage continuing, and the attendant wholly unable to secure contraction of the womb by external manipulation or otherwise.

Holding that the contraction of the womb is the legitimate and natural mode of arresting the hemorrhage, by bending and occluding the sinuses, my thought was that if the contraction could not be commanded by other means, the hand should be inserted and the clot turned out. But it appears that the uterus may refuse to contract, and still the best practice may be not to turn out the clot.

In the *Medical News* (Philadelphia) of October 18, 1884, there is an editorial reciting the points of my last year's paper in a spirit of commendation, and closing with the particulars of a case reported by Lumpe, in a recent number of the *Archiv. für Gynakologie*.

In Lumpe's case, "after the delivery of the child, the uterus did not contract at all but remained relaxed like a leather bag, and its contour could not be felt through the abdominal walls. The placenta was detached but still there was no contraction of the uterus: yet the bleeding was not excessive. More blood was discharged than usual, but gradually ceased, and I felt the cervix coagula. I believe it would have been most improper for me to have removed the blood coagula from the uterus and the vagina, for only the exceptional coagulability of the blood saved the woman from flooding."

With this additional testimony we must surely see that there cannot be an unwavering routine of acts to be gone through with in every case of post-partum hemorrhage, but that in this, as in all other disorders, it is indispensable that the scientific attendant first clearly comprehends the nature of the difficulty he has to contend with, and then as fully understands the principles of the means of relief applicable to the case.

To illustrate another point in practice in cases of post-partum hemorrhage, I submit the following:

I was called at 1 o'clock P. M., August 21, 1884, to see J. G. M. in labor with her first child. She first felt pain at 4 A. M. of same day and the labor progressed smoothly to 3 P. M., when first stage was completed, and I ruptured the membranes, giving exit to a moderate quantity of liquor amnii. The second stage of labor was completed at 4:20 by the delivery of a vigorous boy, and the third stage at 4:50, the delivery of the placenta being assisted somewhat by my fingers. The uterus contracted promptly under massage, but showing a slight disposition to relax, and the patient complaining of more than usual pain after normal first labors, I gave her ten minims of Squibb's fluid extract of ergot and the tenth of a grain of morphia. In a few minutes all appeared to be quiet, and soon after I had left the lying-in chamber, and was adjusting my cuffs in another room, when the nurse notified me that she thought the patient was bleeding too much, and on returning to the bedside I found the patient in great pain; referred to the left iliac region in front and the sacrum in the rear, and that the fundus of the uterus had risen to the umbilicus. I immediately administered twenty minims of fluid extract ergot and a tenth grain of morphia, and resorted to massage of the uterus through the abdominal wall, which induced contraction without reducing its size or position. The patient was lying on her back, now complaining of still greater pain, and I had her turned to her left side, the position in which she was delivered of both child and secundines. The only effect of this turning over was to transfer the pain from the left to the right iliac region, it and the sacrum pain both now so intensified that the victim declared the suffering much greater than at the second stage of her labor. This pain was located where I had not before known in a primipara, and it was of a severity I had not before witnessed in a primipara. It amounted to agony. And added to this the uterus was contracting powerfully under manipulation at regular short intervals but was not at all reduced in size. The pulse had become frequent and feeble, and the prolabia had lost some of their freshness, but no blood was passing the vulva. My diagnosis was that the womb was filled with blood, which the contractions, strong as they were, could not remove.

Here, then, was a case militating against the views I had held and the doctrine I had preached for many years, viz.: that a healthy womb after a normal labor did not have a mischievous clot in it that could not be expelled by its own contractile power, stimulated by external manipulation, rendering it always unnecessary to insert the hand into the organ to turn out the clot, according to the orthodox rule in such cases made and provided.

The case in hand clearly indicated to me the necessity of rendering manual assistance to rid the uterus of the offending clot, and I proceeded promptly to that service. Passing my fingers between the labia, I found the ositum vaginæ closed by a small body, seeming to the touch like a ball of considerable dimensions covered with a serous membrane. This puzzled me. In the attempt to obtain knowledge as to its character by a digital exploration of it, it was ruptured, and my fingers passed into its substance, solving the mystery by demonstrating it a clot of blood, of an extent that plugged up the entire vagina and reaching into the womb. Having determined these facts, it was the work of but a moment to break the vaginal coagulum, and, the contracting womb extruding its contents, the whole mass speedily driven through the vulva, and the uterus on the instant was reduced to its proper size and position, the pain and distress immediately disappeared, everything promptly assumed a satisfactory condition, and all was well. The loss of blood had been considerable, but not enough to require further special attention at the moment, nor did it prevent an ordinary good recovery of the patient.

The outcome of this case declared the correctness of my diagnosis so far as the ultimate facts are concerned, but my views were at fault in supposing the barrier to be the exit of the womb, clot to be at the uterine os instead of the ostium vaginæ, where I found it, and the removal of which cleared away the whole difficulty, rendering it not only unnecessary to pass my hand into the womb, but making it obvious that it would have been bad practice to have done so, leaving me at liberty still to declare that in over forty years' practice I have never met with a case of post-partum hemorrhage when, to save the life of the patient, it was necessary to pass the hand into the womb and turn out the clot.

This paper is intended as a plea, as was the one on the subject last year, for a clear comprehension of the nature of post-partum hemorrhage and of the principles which should govern in its management, to the end that the accoucheur, when suddenly brought face to face with the alarming difficulty, shall at once recognize the essential points in the particular case before him, see promptly what ought to be done and promptly do it, not failing to turn out the clot if such procedure is best, but not feeling that he must pass his hand into every womb when there is a hemorrhage after childbirth because such violent proceeding is sometimes necessary. The scientific dogma in this, as in all other therapeutic procedures, should be that the simplest measure that is promptly efficient is the best.—*J. F. Hibberd, M. D., in Fort Wayne Journal of Medical Sciences.*



## POISONING BY CHLOROFORM INTERNALLY ADMINISTERED.

Since chloroform administered internally in the treatment of tape-worm has frequently been referred to in these columns, the following case of poisoning through the accidental administration of an overdose, reported in the *New York Medical Record* for October 3, by Dr. J. M. Latta, of Millerton, Kansas, is deserving of attention:

The case was that of a boy, six years of age, suffering from tape-worm, for which he ordered a mixture of one part chloroform in three parts simple syrup, of which one teaspoonful was to be given every hour until four doses had been taken. By mistake the parents gave the mixture in tablespoonful doses. Twenty minutes after he had taken the fourth dose of the mixture the boy said the medicine was "about to kill him:" he reeled like a drunken person and vomited violently, throwing up mucus tinged with blood. The child was rational when first seen by Dr. Latta, and said that his stomach hurt him, but in a few minutes he became unconscious. The pupils were normal, the breathing easy, and the pulse a little accelerated, but regular, and rather full and bounding. The face was covered with an even red flush, arterial in tint. The temperature was not taken. It was impossible to arouse the boy by calling or shaking him. All the pillows were removed, the body was placed straight and all constricted portions of clothing loosened, and fresh air was freely admitted into the room. The pulse and respiration were carefully watched, but as they furnished no special indications for treatment, nothing more was done. The pulse became gradually less rapid, the flush disappeared from the face, and in an hour and a half the boy awoke and expressed himself as being all right. A saline was administered a few hours later and the bowels were moved, but there was no appearance of any tape-worm.—*Therapeutic Gazette*.

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A CASE OF ATROPINE-POISONING SUCCESSFULLY TREATED BY JABORANDI.

Dr. Suzuki reports in the *Transactions of the Sei I Kwai*, August, 1885, the case of a woman aged nineteen, who drank a tablespoonful of "miso shiru" (a kind of pea-soup) in which a certain quantity (about half a grain) of sulphate of atropine was mixed by an insane person. Immediately after she felt a disagreeable bitter taste, so that she tried to vomit by tickling the throat with her fingers, and succeeded in vomiting a small amount



of the contents of her stomach. About half an hour after the event she complained of headache, giddiness, flushing of face, dryness of mouth, and weariness. When she came to Dr. Suzuki her pulse was frequent, the conjunctivæ dilated, the mouth and the nares were dry. He gave her immediately a solution of eight grains of tannic acid in one and a half ounces of water, and repeated again the same dose after five minute's interval: at the same time with it the ice-bag was applied to her head, but the symptoms continued to increase in severity and without the slightest effect being produced by the measures taken. At 11 o'clock A.M., paralysis of the tongue was noticed, articulation and deglutition became difficult, the extremities were cold, the pulse was weak and thready, and she was restless and delirious, presenting symptoms almost like insanity. A warm infusion of jaborandi, one grain of the leaves to four ounces of boiling water, was administered at once, and in about ten minutes after its exhibition the serious symptoms gradually subsided. After about an hour and a half the pupils began to contract, the tongue moistened slightly, and the articulation became distinct, but general debility, paralysis of the left arm, thirst, and fullness of the stomach persisted. At this time the patient said that she felt as if the intoxication had passed over, but she did not recollect what had occurred during the attack. The next morning she only complained of a slight headache and diminished appetite. No other symptoms remained.—*Therapeutic Gazette*.

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### MERCURIC BICHLORIDE IN ENTERIC FEVER.

W. Greifenberger (*Berliner Klinische Wochenschrift*, No. 38) concludes that abortion of typhoid fever with calomel is due to purgative action in first order: and that since repeated large doses of calomel cause no further evacuation, the subsequent influence of calomel is due to the disinfecting power of such portions of it as are converted into corrosive sublimate by the acidity of the gastric juice. As sublimate may be given at any stage without danger to the intestines, he has used a solution of one grain of corrosive sublimate and an ounce of simple syrup or of peppermint and water, with sufficient water to make eight or ten ounces. Of this, one tablespoonful is given every hour or two, or about half of the above mixture in twenty-four hours. Infusion of digitalis, or morphine, may be added to the solution. The bowels may be regulated by castor oil or senna. While sublimate is given let the patients gargle frequently, and be fed with gruel and yolk of egg. The sublimate is usually given three or four days. Prostration was treated with tincture quinine and muri-

atic acid,' camphor, ether-camphor, etc. Dr. G.'s success was remarkable. The method is cheap, simple, and better than mercurial inunction.—*Med. Annals.*

### A PLEASANT QUININE MIXTURE FOR CHILDREN.

The *Canada Lancet* says that a most pleasant and palatable disguise for quinine may be extemporized as follow :

R.	Quiniæ sulph.,	12 grs.	
	Acidi tannic,	20 grs.	
	Tinct. opii camph.,	$\frac{1}{2}$ oz.	
	Tinct. cinchonæ,	$\frac{1}{2}$ oz.	
	Spts. lavand eo.,	3 dr.	
	Syrup simp., ad.,	4 ozs.	M.

Shake well before using. The dose will be usually one teaspoonful three times a day, but the amount of quinia desired to be administered should govern the size of the dose. It will make a beautifully creamy mixture, if the quinia and tannin are rubbed together on a pill tile or a sheet of paper with a spatula until all lumps disappear, then put in a suitable bottle and first add the paregoric, shaking at once, then the cinchona and lavender, followed by the syrup.

### OX-GALL IN TYPHOID FEVER.

Dr. George Van Schaick (*Quarterly Bulletin*) regards the tympanites, high fever and mental disturbances as largely due to changes in the liver, which result in diminution of secretion of the bile. With this belief he tried ox-gall in enteric fever, the patients being fed on milk and fluid diet, which probably needs but little bile.

His first case was seen on the sixth day of the attack, at which time the morning temperature was  $103\frac{3}{5}$ , and the evening  $105\frac{3}{5}$ . On the next day the eruption appeared, and the morning temperature was  $103\frac{4}{5}$ . At 3:30 P. M. he gave 1 dr. pure gall in gelatine capsule, and at 4 P. M. fifteen minims more. The result was an evening temperature of 104. After this he gave  $1\frac{1}{2}$  to 3 drachms of bile daily, and nothing else. The patient did well in every respect, her temperature never exceeding 103, except on one day, when the butcher failed to get the bile, when it reached  $105\frac{3}{5}$ . But it was immediately reduced upon resumption of the drug.

In the second case the highest temperature reached was 104 on the eleventh day. The bile was pushed in this case to 1 oz.

daily, but no special result was observable, and the dose was again reduced to 1 dr. three times a day.

In the third case antipyrine, quinine, cold affusion, etc., were used, but the tympanites, hebetude, weakened heart's action and a temperature of 105 $\frac{1}{2}$  soon showed the treatment useless, and bile was begun. The following day the evening temperature was 103 $\frac{1}{2}$ , and the patient continued to an excellent recovery.

Altogether the author was pleased with the results, though aware that three cases are not sufficient to establish the treatment over all others.—*Med. Annals.*

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### NIGHT-COUGH IN YOUNG CHILDREN.

The author concludes a paper published in the *Medical News*, February 28, 1885, as follows: It is a well-known fact that a drink given to the child will often cause a cessation of the paroxysm, the fluid simply pushing downward the exciting foreign body. This clinical fact gives us the clew to the successful management of these troublesome cases. If the nasal passages are thoroughly cleansed before the child is put to bed, the night will probably be uninterrupted by this irritative cough. If the discharge accumulates in the nasal passages or upper pharynx during the night and gives rise to a paroxysm, it is a simple procedure to cleanse the nasal chambers, and at once relieve the symptoms. Treatment can be most effectively carried out by means of spray composed of an aqueous solution of an alkali. By its use these cases need no longer be harassing to either practitioner or patient.

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### THE INFECTION OF SCARLET FEVER.

It is reported by the Medical Committee appointed to inquire into the alleged recurrence of scarlet fever at an orphan asylum, from a premature discharge of patients from the institution for infectious diseases at Liverpool, that a failure to cleanse the head thoroughly is by no means a rare cause of retained infection of the disease, the desquamation of the scalp being taken for "scurf." Another common source of the contagion was found to be the clothing which the children had worn at the time of their admission to the institution, this being sent away with them after being, as it was thought, thoroughly disinfected. *Maryland Med. Jour.*

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THE PEORIA MEDICAL MONTHLY, a practitioner's journal.  
Two dollars a year, in advance.

## THERAPEUTIC NOTES.

## HEADACHE DUE TO RENAL POISONING.

- R. Hydrg. bichlorid., 1 dr.  
Tinct. ferri perchlor.  
Glycerine, aa  $\frac{1}{2}$  oz.  
Aquæ puræ, ad 12 ozs.

M. A tablespoonful in an equal quantity of water or one ounce of infusion quassia, three times a day. This for headache where due to renal congestion, with anasarsa and anæmia, and in some forms of syphilitic headache when the cachectic state is marked.

## HEADACHE FROM MALARIAL POISONING.

- R. Liquor fowleri.  
Tinct. belladonna, aa 1 dr.  
Aquæ puræ, ad  $1\frac{1}{2}$  oz.

M. Sig.—A teaspoonful in a wine-glassful of water three times a day. In headache from malarial poisoning, when it recurs from time to time.

The above formulæ as well as the following, are from Dr. Day's monograph on "Headaches":

## HEADACHE OF CEREBRAL ANÆMIA.

- R. Ext. gentian.  
Ferri sulph.  
Pulv. digitalis, aa 12 grs.  
Pulv. cinnamom., 6 grs.

Misce et divide in pil. No. 12. Take one three times a day.

In the headache of cerebral anæmia, where digitalis is required; where there is unsteadiness of the heart's action after food, and there is flatulence, the iron may be advantageously omitted, and pulv. zingib. substituted for pulv. cinnamom.

## CHRONIC DIARRHŒA.

- R. Acidi nitrici diluti,  $\frac{1}{2}$  dr.  
Liquoris opii sedativi  
(Battley), 1 dr.  
Ticturæ gentianæ,  $\frac{1}{2}$  oz.  
Infusi gentianæ,  $4\frac{1}{2}$  ozs.  
Aqua menthæ piperitæ  
fort., ad 8 ozs.

One ounce to be taken three times a day.

In chronic diarrhœa, of probable neurotic origin in females of nervous temperament, Dr. J. Vase Solomon (*Brit. Med Jour.*) has found the above quite efficacious.

## MALIGNANT SCARLET FEVER.

- R. Acid. salicylat, 2 dr.  
Tinct. aconit. radicis, 12 drops.

- Inf. digitalis,  $1\frac{1}{2}$  oz.  
Spts. ammon. arom., 3 dr.  
Syr. auranti. cort.,  $\frac{1}{2}$  oz.  
Aquæ, 1 oz.

M. Sig.—Teaspoonful for a child five years old every three hours. In malignant scarlet fever, with cold extremities and tongue and high temperature.—*Dr. B. Brown, Alexandria, Va.*

## TREATMENT OF NEURASTHENIA.

Dr. M. L. James, of Richmond, Va., recommends highly the following formulæ in the condition of neurasthenia and its accompanying digestive troubles, together with a most careful attention to the diet:

- R. Quiniæ phosphat, 32 grs.  
Strychniæ phosphat,  $\frac{1}{8}$  gr.  
Acid phosphorci, 40 min.  
Caffein. citrat., 32 grs.  
Aquæ puræ, fl. 14 drs.  
Glycerinæ puræ.  
Spts. vini rectificat, aa f. 1 oz.  
Tinct. card. comp., f. 2 drs.

Misce secundum artem.

Sig.—One or two teaspoonsful immediately before or after breakfast and dinner.

He referred to those extreme cases where the disorder of the stomach was such that the patient could not ingest the foods ordinarily in use, and for those cases he indicated the use of such fluid diet as Valentine's Beef Juice, or foods predigested by the use of pancreatine and pepsin; and in those cases attended by such aggravation that the stomach would tolerate no food at all by articles similar to those, alimentation should be maintained through the rectum.

## FOR RHEUMATISM.

- R. Guaiaci (vit ovi semel), 1 scruple.  
Aquæ dest., 1 oz.  
Liq. ammon. acet., 2 drs.  
Syrupi, 1 dr.

M. For one dose.

—*Dr. E. J. Clark.*

## TO PRODUCE DIAPHORESIS IN FEVERS.

- R. Inf. serpentariæ, 9 drs.  
Ammoni carb., 5 grs.  
Syrupi, 1 dr.

M. Sig.—To be taken twice daily.

—*Dr. Paris.*



# THE PEORIA MEDICAL MONTHLY.

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\*The Editor is not responsible for the statements or opinions of contributors.

\*Short original articles are invited from any reader, whether a subscriber or not.

\*If extra copies are desired by a contributor, the number must be specified when the article is sent to the Editor.

\*All exchanges, books for review, and communications must be addressed to the Peoria Medical Monthly.

\*The publication day of this journal is on or about the 25th of each month.

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## EDITORIAL.

### ANNOUNCEMENT.

As will be noticed elsewhere, the working force of THE MONTHLY has been increased by the addition of Drs. Will and Coulter to the editorial staff, and we feel no hesitancy in saying that the well-known ability and energy of these gentlemen will soon be felt in the conduct of our journal. It is our intention to push THE MONTHLY still nearer to the standard that has in the past been aimed at, and we hope to make it a necessity to every physician in our State, as well as a welcome and helpful visitor to a very large number of practitioners throughout our country. THE MONTHLY has friends that are now numbered by thousands, and if each one of this large number will take a little interest in its further spread by speaking a good word for it among his medical friends, its growth will be still more rapid. Will *you* not help us?

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### MIND CURE.

Apropos of the "Mind Cure," or "Faith Cure," craze which is now prevailing in this and other sections of the country, the

following letter, written by a lady not far from here to a friend in this city, and published in a late number of *The Saturday Evening Call*, may not prove uninteresting to our readers:

“MY DEAR FRIEND: I wrote to congratulate you upon your wonderful recovery. I understand that it is, if anything, too complete. The ardor with which Mrs. — hurled herself upon your case occasioned surprising results. I am told she surprised even herself. It is reported that your hearing has so greatly improved that you have been obliged to give up wearing your watch, the loud ticking of which disturbs you, even when it is reposing in your pocket. That you are now able to hear yourself think is well known.

“While I congratulate you heartily, her failure in my case leads me to deep self-abasement. I did not suppose I was a tougher subject than yourself, but so it seems. Well, neither Mrs. —, nor any of her followers, can wave me like a banner from the outer wall and say ‘mind cure did it;’ because it didn’t do it. From the first, Mrs. — eyed me with suspicion. And why should she? I merely sought for information, free, and that in the humblest manner, but I didn’t get much.

“When I asked her why, if the mind-power was infinite and could control everything, she could not overcome sleep, hunger, thirst and cold, and all the other wants of the body, she said: ‘Shut your eyes now. I want to get in my work,’ or words to that effect.

“So she shut hers at the rate of a dollar a minute, and I closed mine for nothing. When I pointed out to her how convenient and economical it would be to ignore the body altogether she did not seem impressed. I pointed out to her as gently as I could the advantages of this system. No young man need be afraid to marry now. Salary is no object. All he has to do is to tell his bride: ‘No, you are not hungry, nor cold, nor tired. No, you don’t want a new dress: you just imagine it!’ and the thing is done. I also inquired, always in the same humble tone, if the force of her will could keep a ball thrown into the air from falling; also, if, as she said herself, no one could get cold, nor feel tired or overdone under this system, it were possible to walk for years without fatigue. She claims no limit. At this stage of affairs it seemed to occur to her that, in the words of the poet, I was getting ‘too much sugar for a cent,’ so she replied that at the lectures all these things would be explained—price \$15.00.

“But I did not have fifteen dollars’ worth of curiosity concealed on my person, so I refrained from pursuing the subject. Like the boy who set one hundred eggs under a hen to see her ‘hump herself,’ I asked her these questions, but she did not hump

herself to any great extent. Now I believe for some things Mrs. — is a great success. You know they say if you put a chicken's beak on the ground and draw a chalk line from its bill to any given point, it will imagine itself tied and never try to move. Now Peoria contains a good many of these chickens. They have been thinking themselves fastened down for years, and have not tried to move. Along comes Mrs. — and wipes out the chalk mark. Off goes the chickens (hens mostly). How many fathers have cause to bless her! But I would like to see her try some one who was chained and fastened by actual acute disease.

"This is what I think, and all I know concerning 'mind cure.' We are working it for all there is in it in our family at present. Gus is trying to persuade me that I don't want a seal skin sacque—I only imagine it. But, while the theory is all right, in this individual case the experiment fails. I do not believe all the 'healers' in the country could convince me of that.

"Father asked me what I thought of the 'mind cure.' Give him this to read, and let him see for himself.

"Yours sincerely,

\* \* \*

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### A WAIL FROM CHICAGO.

Recently, a Dr. Waugh was assassinated by one Sweet, who was actuated thereto by a criminal intimacy existing between the Doctor and Mrs. Sweet. The grand jury failed to find a true bill against Sweet and he was discharged. Now, the *Western Medical Reporter* makes this action of the grand jury the text of a wail because of the "one-sidedness of public opinion whenever and wherever a physician is involved." It is true the *Reporter* does not condone the offense, of which it admits Dr. Waugh was probably guilty, but it claims that probably Mrs. Sweet was the seducer, and that the poor Doctor was her game. From the *Reporter's* statement, the lot of a Chicago physician must be a most unhappy one. It says:

"There is hardly a physician in general practice, but can testify that the profession of medicine is one which is attended by great temptations at the hands of persons who consider the doctor to be a man who is fair game, and whose best interests lie in the direction of discreet silence. Verily, between such persons on the one hand, and professional blackmailers, hysterical subjects and nymphomaniacs upon the other, not to speak of a touch of that human nature, which makes all men kin, the doctor is in a

worse predicament than was poor Odysseus, for he could hope to escape from both Scylla and Charybdis in a reasonable time, while your poor devil of a doctor is menaced by them throughout the whole of his professional career."

If this be true, we give it as a solemn warning to all physicians who contemplate moving to Chicago, and offer our sincerest sympathies to those who are so unfortunate to be unable to leave such a crime-sodden city.

The *Reporter* thinks the law should be interpreted, "Thou shalt not like anyone but doctors," and suggests this may be a satisfactory answer to "What shall we do with our graduates?" Hereafter we shall employ a body-guard whenever we visit a Chicago doctor's office.

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#### AN ATTACK ON DR. N. S. DAVIS.

The *Iowa Medical Reporter* continues to attack Dr. N. S. Davis, of Chicago, in a very bitter manner. It accuses him of grave misdemeanors as Dean of the Chicago Medical College, and demands that he be retired, both from his deanship and as editor of the *Journal of the American Medical Association*. We have not yet seen any defense from Dr. Davis, and we doubt whether he will make one. With all his faults, no one has yet dared to accuse him of unethical conduct or disreputable practices, and it would take overwhelming evidence to convince us of his guilt in these directions.

Dr. Davis is often dictatorial, approaching nearly to arrogance, in his manner, but we have always believed that this was due to the power of his convictions rather than to any disposition to be unfair or unjust. As to his being dishonest, the idea is ridiculous.

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#### SMALL-POX IN PEORIA.

Reference has already been made to the prevalence of this disease in this city during the past few months. It is almost entirely confined to the lower portion of the city, and is not spreading very fast. The total number of cases to date is sixty-nine, with six deaths. Vaccination has been pretty generally prac-



ticed, and the health board claim to have the scourge under complete control.

As usual, we have some anti-vaccinationists who cannot refrain from airing their opinions and names in the public press (mostly the German press), and thus foster the common, ignorant hostility to this valuable procedure, but the general public is in favor of vaccination and uphold the health officers in executing their plans to control the disease.

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### OFFICE THIEF.

A young, rather heavy-set man, with large sandy mustache, engaged in selling second-hand medical books at ridiculously low prices, passed through Peoria a short time ago. At the same time several physicians missed various books, but afterwards found them in the hands of other physicians who had bought them from a man answering to the above description. The police were too lazy to make any attempt at his arrest, although ample notice was given. Look out for a second-hand man.

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### GREAT OFFER.

All new subscribers sending \$2.00 before December 31st will receive the MONTHLY from November 1885 to May 1887. This is an offer worth considering. All readers will confer a great favor, if they will call the attention of their medical friends to this offer.

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### NOTICE TO SUBSCRIBERS.

Owing to the changes made in the publishing department of the MONTHLY, it will be necessary for all delinquents to pay up by December 31st. We wish to open a set of "clean" books with the new year.

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### MARRIED.

Dr. Charles F. Ross (Rush '81), of Saunemin, Ill., was married November 5th to Miss Grace D. Mills. The "boys of

'81" will surely congratulate the doctor on his wise course. Shake, doctor, shake.

Our jovial friend Dr. W. H. Conibear, of Morton, Ill., was married October 29th to Miss Mary A. Bogardus. May his shadow never grow less, nor his laugh grow faint. We beg to offer our sincere congratulations.

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### DEATHS IN THE PROFESSION.

Dr. William B. Carpenter, a well known writer on physiology, died in London, Eng., Nov. 9th, aged 73 years.

Dr. Fehling, Stuttgart, Germany, (inventor of the sugar test), July 1st, aged 73.

Dr. A. C. Fessenden, Eastport, Me., Oct. 22d, aged 66 years.

Dr. Jas. H. Snodgrass, Pittsburgh, Pa., July —, aged 53 years.

Dr. Thad. M. Stevens, Indianapolis, Ind., Nov. 7th, aged 56 years.

Dr. A. T. Keyt, Cincinnati, Ohio, Nov. 9th.

Dr. Jno. L. Atlee, Lancaster, Pa., Oct. 1st, aged 85.

Dr. Richard McSherry, Baltimore, Md., Oct. 7th, aged 68.

Dr. Samuel G. Armer, Brooklyn, N. Y., Oct. 27th.

Dr. W. W. Goldsmith, Louisville, Ky., Nov. 2d, aged 64.

Dr. Wm. K. Bowling, ———, Tenn., Aug. 6th, aged 77.

Dr. J. N. McChesney, New York, N. Y., Sept. —, aged 33.

Dr. E. A. Hildneth, Wheeling, W. Va., Aug. 31st, aged 64.

Dr. F. D. Cunningham, Richmond, Va., Sept. 9th, aged 49.

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### QUESTIONS.

Several applications for therapeutic information have reached us during the past month, with the request that we put them before our readers, and that they be answered by several in the next issue. Let us have numerous replies.

1. DR. —, *Wisconsin*.—Asks for the best method for disguising the taste of quinine, especially for administration to children.

2. DR. M., *Illinois*.—Says. I have a case of sweating—boy aged 9 years, fairly nourished, had a "bad cold" four years ago.

since then he sweats every night when in bed; if he would not go to bed, he would not sweat. He sweats only from neck to knees. Have tried acids, atropia, ergot, and a host of other remedies without any relief. *I want help.*

3. DR. L., *Kansas*.—Have any of your readers had any experience with antipyrin? I ask country doctors who have tried it. I am somewhat skeptical about hospital reports in the big journals, and put more dependence on reports from plain doctors like myself. Is antipyrin worth trying?

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### NOTES AND COMMENTS.

A Siberian priest in the village of Troitzky claims to have successfully inoculated cows against the Siberian plague many years before Pasteur began his experiments in the same field.

Cremation would appear to be gaining ground. The newest organization favoring it is called the New England society, at Boston, which has just been incorporated with a capital stock of \$25,000.

In speaking of premature menopause, Dr. T. G. Thomas said: "When called upon to express an opinion in the early part of a supposed pregnancy, you should always say that up to the end of the third month no one can decide the matter by even the most careful examination."

Says the *Medical and Surgical Reporter*: A wealthy farmer of Whitewater, Indiana, traveled around with a cancer doctor one day for fun. The funniest thing about it all is the suit which one of the doctor's patient's executors are now bringing against the wealthy farmer for looking at the doctor kill her.

Dr. Thomas M. Hope died at Alton, where he had resided for over half a century. He was a surgeon in the war with Mexico, in which campaign he fought a duel with Dr. E. B. Price. He served one term as Mayor of his city, and in 1860 was the Breckinridge candidate for Governor of Illinois.

By the way, the last kind of a cold (for men only) is an "overcoat cold." This is the name given by the London *Lancet* to the cold a man takes from wearing a thin overcoat on a coolish kind of a day, when it seems, according to the *Lancet*, he

should simply have put on a thicker coat, waiting until cold weather to don a heavy overcoat.

One of the small-pox curiosities at Montreal last week was a cat who had a well-developed attack of the disease. The serenader had been fondled by an afflicted child during its illness, and after the death of its little guardian, exhibited symptoms of the disease. When the health officers went to disinfect the premises the cat was found to be covered with pustules. The afflicted grimalkin was promptly shot and cremated.

The making of a doctor in the old country is a process involving years of study and severe examination. This has a disastrous effect on the intellectual faculties of such women as may seek to become full-fledged medicos. In the year 1881 there were but twenty-five women practicing medicine in England and by the end of 1884, or three years later, eight of them were in various foolhouses, while three others died prematurely.

Sir James Paget has been tracing the course in life of 1,000 medical students, taken at random from an English institute. He found that twenty-three out of the 1,000 achieved distinguished success; sixty-six had considerable success; 507 made a living; 124 had a very limited success, not having made a fair practice within fifteen years after graduation, and fifty-six failed utterly. Nearly 10 per cent. (ninety-three) of the whole number left the profession after beginning either study or practice, eighty-seven died after entering practice, and forty-one died when students.

Not only do calves furnish vaccine virus, but they create a demand for it as well. This may seem paradoxical, but this is the way of it. Human subjects who have been vaccinated several times upon an arm, or who may fear disfigurement by the operation, are now vaccinated upon the calf of the leg. This method has also been found convenient in vaccinating babies and young children. Almost everyone grabs a baby by the arm in lifting it, to its decided inconvenience soon after inoculation. All this is avoided by vaccinating the patient on the calf.

A daily paper amongst our exchanges contains the following: "It is a part of the small humor of the day to taunt the doctor with his want of skill, to hold him jestingly responsible for



man's failure to combat death itself; to charge him, indeed, in mockery of our human weakness, with being recreant to his knighthood and in league with the hosts of death. But even this gibe has a ghastly echo; when we utter it we know that it has no truth. We know only too well that when the doctor shakes his head and turns away, and when his cheery fictions lose the glibness of their flow, that we ourselves haul down the flag in helpless surrender."

A newspaper exchange contains the following very pertinent remark: "See here, girls, Dio Lewis, a medical gentleman, who writes a few lines of common sense and dead loads of balderdash, says that cutting the hair short at the back of the head induces baldness. If this be true what a crowd of smooth-pated girls we will have about this settlement in a year or two! The main thing to find out now is whether, in making this statement, Dio Lewis wrote it with his common sense or his balderdash pen. Opinions on this subject will be equally divided among those who have shed their back hair and those who still retain it."

There are some people who can handle the poison ivy with impunity; a great many suffer a good deal of pain and annoyance from its touch; and some there are who cannot go within fifty feet of it, if the wind should be blowing toward them, without their hands, faces, and sometimes their legs, swell up like puff balls, the whole surface being covered with horrid little itching, watery pustules. Singularly enough a church was recently dressed with poison ivy, among other things, and most of the persons present were badly poisoned. I know a New York editor who is sometimes totally incapacitated for business for two weeks or three weeks at a time from this cause; and then it is interesting to notice how mad a very mild-tempered man can get. I have been poisoned myself, and was advised by an old lady in the country to use a tea made of the sweet fern (*comp-tonia aspienifolia*), and found it so smooth and curative that I always recommend it. The tea or decoction should be made strong. It is not to be drank, but rubbed on freely, and left to dry. It stains the parts a deep yellow, but is easily washed off.—*Exchange*.

## BOOK NOTICES.

A REFERENCE HAND BOOK OF THE MEDICAL SCIENCES. Illustrated by chromo-lithographs and fine wood engravings. Edited BY ALBERT H. BUCK, M.D. Small quarto, pp. 808, Aac. to Cat. Vol. I. New York. Wm. Wood & Co. 1885.

This invaluable series will consist of eight volumes to be completed within the next two years. When finished it will fill a place in medical literature that no other work occupies. From its title we learn that it is "a complete and convenient work for reference for information upon topics belonging to the entire range of scientific and practical medicine, and consisting of a series of concise essays and brief paragraphs arranged in the alphabetical order of the topics of which they treat." The names of ninety contributors to the work are given and nearly all are citizens of our own country. This fact will make it essentially an American work, and will render it all the more acceptable to American physicians. It is not like Ziemssen's great work an encyclopedia of medicines only, but it is an encyclopedia of everything relating to medicine, including botany, chemistry, histology, toxicology, etc., etc., a whole library in itself, and elegantly printed. We predict an immense sale for the work, and advise all who can to buy it. The price is moderate, six, seven and eight dollars a volume, according to binding.

A FORMULA BOOK. How to use Listerine. Lambert Pharmaceutical Co., St. Louis, Mo.

A neatly printed little book of 32 pages, full of formulæ, with instructions how to use this popular antiseptic, both internally and externally. Listerine has a wider range of usefulness than many suppose, which fact is attested by the writings of many eminent specialists in the country. Free on application to the publishers.

Several books received will be duly noticed in the December number, being crowded out of the present issue.

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 RECEIPTS.

The date following each name, indicates where the amount credited extends the subscription:

ILLINOIS.—Drs. E. E. Reynolds (1.00) November, 1885; A. Grim (2.00) January, 1886; Jno. Wright (2.00) June, 1886; A. R. Graham (2.00) January, 1886; F. G. Shipp (2.00) January, 1886; H. Knappenberger (2.00) February, 1886; S. C. Latham (2.00) April, 1886; W. H.

Veatch (2.00) January, 1886; C. T. Dripps (2.00) May, 1886; E. L. Fridenberg (1.00) November, 1885; Geo. Bratton (2.50) May, 1886; A. R. Howard (2.00) February, 1886; W. R. Mizelle (2.00) June, 1886; R. F. Harris (4.20) November, 1885; John Becker (2.00) January, 1886; N. F. Felker (2.00) January, 1886; W. O'Brien (1.00) November, 1886; J. Henry (2.00) January, 1886; W. J. Thurman (1.00) November, 1885; R. C. Poos (4.50) May, 1887; A. F. Burnham (2.00) July, 1886; J. Wills (2.50) June, 1886; M. S. Marcy (2.00) June, 1886; A. L. Craig (2.00) May, 1886.

IOWA.—Drs. B. F. Hyatt (1.00) December, 1885; D. W. Overholt (2.00) January, 1886, Shelton & Son (2.00) August, 8 6.

MISSOURI.—Drs. S. F. Bonney (1.00) January, 1886; J. H. Bencher (2.00) June, 1886.

DAKOTA.—Dr. E. M. Bentley (2.00) December, 1885.

INDIANA.—Dr. M. L. Humsten (2.00) February, 1886.

WISCONSIN.—Drs. W. H. Earles (1.00) December, 1885; Day (2.00) March, 1886; W. Monroe (3.00) May, 1886; O. N. Murdock (2.00) June, 1886.

NEBRASKA.—Dr. Geo. G. Case (2.00) January, 1886.

TEXAS.—Dr. A. Garwood (5.00) August, 188—.

KENTUCKY.—Drs. Duncan & Douglas (2.00) May, 1886.

MINNESOTA.—Drs. F. H. Welcome (1.50) November, 1885; F. Iberson (2.00) June, 1886.

OHIO.—Dr. D. S. Hartinger (2.00) June, 1885.

CALIFORNIA.—Dr. W. V. Grimes (1.00) December, 1885.

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Messrs. Parke, Davis & Co., Detroit, Mich., propose to furnish physicians and students in medicine and pharmacy an elegant, efficient and most valuable aid to the practical study of vegetable materia medica. It consists of a collection of all crude drugs of vegetable origin recognized in the United States Pharmacopœia, and many not so recognized that are in common use. The specimens number two hundred and eighty-eight in all, and are contained in a substantial black-walnut case, which is twenty-three inches long, sixteen inches wide, and thirteen and one-half inches in depth. The manufacturers offer this splendid collection at the very moderate sum of ten dollars; but to be able to put it forth without pecuniary loss, they must be secured in the sale of fifty sets. No doubt the guaranty will be made good at an early day, and the collection thereby placed permanently among the helps to the study of medicine and pharmacy.

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I have prescribed *Fucus Marina* (Peacock), and find that it will do all that is claimed for it. As a malarial antidote (and to prevent the return of ague after it has been checked with quinine), it surpasses any agent I have ever employed. I shall continue to prescribe it whenever it is indicated.

I. N. GRAVES, M. D., Dongola, Ill.

# THE PEORIA MEDICAL MONTHLY.

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## ORIGINAL COMMUNICATIONS.

### FLEXION OF THE THIGH, WITH THE LEG IN THE STRAIGHT POSITION, FOR SCIATICA.

BY ALBERT B. STRONG, M. D., CHICAGO, ILL.

I have frequently obtained valuable ideas from the short, pithy articles in THE MONTHLY, and I owe something to it for value received, besides keeping up my subscription.

There are many "wrinkles" in practice, and I offer you one, for the many received, that has served me well.

*Case*—A short time ago I was called to see a laborer suffering acutely from a severe attack of sciatica of the right nerve. He was 55 years old, always enjoyed good health, with the exception of some seven years ago, he had a similar attack that confined him to the house for eight weeks. In the mean time the limb had remained well. He never had rheumatism or specific disease.

The present trouble began three weeks before I saw him. For the last week he had scarcely obtained any rest day or night. The pain was present all the time down the back of the thigh as far as the toes, and in the region of the groin..

It was paroxysmal, worse at night and so intense, particularly in the calf of the leg, that it felt, as he said, as though a dog had grasped the muscles and was tearing them from the bone. The great and adjoining toe was numb. He obtained



the greatest relief by sitting by the fire almost constantly, grasping the knee with both hands and flexing the thigh strongly upon the abdomen. When the paroxysm would come on in the night he would throw off all covers and feel some better by lying perfectly naked in a cold room. At other times he would obtain some relief by standing up, grasping a table with both hands, getting half way down on his left knee, throwing his right lower extremity as far back as he could and putting all his weight on the toes of his right foot.

Standing thus for a few moments, the paroxysm would disappear, and on going to bed would sleep for an hour or so. I requested him to lie down upon the lounge. He walked to it a few feet distant, with much difficulty, and hitched himself on to it, all the time holding the right extremity perfectly rigid. He lay on his back. I grasped the ankle with one hand, the knee with the other, and so keeping the leg perfectly straight, gradually flexed the thigh to a right angle with the body. This caused him excruciating pain, referred chiefly to the point of exit of the nerve and to the calf. The limb was held in this position for about five minutes when the pain gradually disappeared. On lowering the limb he instantly remarked that it felt much better; that he had not for three weeks been able to allow the leg to rest upon its calf as it was now doing. He was requested to get up and walk about. He began to do this in a stiff and awkward sort of a way, but finding that the accustomed pain was gone, completed the remainder of the process in a surprising agile manner. He began to walk at first cautiously, then more boldly, till in a few minutes he walked nearly as well as ever and entirely free from pain.

The instant relief from his sufferings was a source of great surprise to him and satisfaction to me. I again went through the same manipulation; this time but little pain was produced.

Ordered 12 capsules, each containing morphia sulph.  $\frac{1}{8}$  gr., quiniæ sulph. 3 gr., to be taken every four hours. Instructed him to bend the leg next morning should the pains return.

Saw him again the third day. There had been no return of the paroxysm and he felt much better in every way: complained only of numbness in the great and adjoining toe. Left off the morphine and continued the quinine for three days more

when I saw him for the last time. He had slept well from the first, walked with perfect freedom and free from all pain, only complaining of numbness in the toes.

That the sciatica nerve can be very materially stretched, was rendered quite apparent when I cut down upon the nerve in a cadaver, put my finger under it on the quadratus femoris and made the manipulation as described above.

The finger in this position was almost painfully compressed.

The ham-string muscles were also rendered very tense. The tension of the nerve and muscles of the calf can be greatly increased by firmly flexing the foot on the leg while the lower limb is in the position as above described. It is well known that the thigh can be brought in contact with the abdomen; but with the leg extended the thigh, in the adult at least, cannot, as a rule, be flexed much beyond a right angle without doing violence to the parts.

I hope some of your readers will make this simple manipulation in similar case and report the result.

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## THE HEART AND PULSE IN ORGANIC FUNCTIONAL DERANGEMENT AND DISEASE.

BY JAMES S. WHITMIRE, M. D., METAMORA, ILL.

(Read at a meeting of the N. C. Medical Association, at Metamora, Ill., Tuesday, Dec. 1, 1885.

*Mr. President, and Gentlemen of the Society:*

I have thought that a limited paper, written from observation and an experience acquired in the course of a forty years country practice, might be neither uninteresting nor uninstruc-tive to our membership, on the significant symptoms developed by the pulse, and occasioned by the action of the heart, in organic functional derangement and disease.

In all ailments, whether occasioned from simple functional derangement of the physiological action of any of the organs of the animal economy, or from absolute disease, the heart—the great center of the circulatory system—is the first organ of the body to sympathize with the condition and sound the alarm to the general system, and notify it that all is not right within the organism. This notification is indicated either by the force and

frequency of the heart's action, or by the feebleness or other character of the cardiac impulse given to the blood through the arterial system, and made manifest by the tension or relaxation of the elastic walls of the arteries.

These manifestations denote the different characters of the pulse, represented by the different manifestations presented. The pulse may be divided into and designated by certain names, which may be readily recognized by an accurate observer.

There is, first, the natural pulse of childhood, of youth, of vigorous manhood, and finally, that of old age; second, the pulse in disease, or organic functional derangement, may be divided, primarily, into frequent, quick, full, tense, full and soft, and an intermitting, and also, an irregular pulse. These are the principle characters and designations by which the pulse is known; but it must be remembered that all these varieties of the pulse may, and do merge into one another, or partake, at the same time, of one or more of these varieties of the pulse, according to the circumstances under which they are induced. To begin, then, I will state that a normal pulse is one that belongs to a healthy individual at a given age; and the average rate may be stated, according to our best and most critical observers, to be, at birth, from 130 to 140 per minute, the circumstance of sex, at this time of life, not having any apparent influence on the pulse rate; from the 2d to the 5th year it runs from 100 to 120; from the 6th to the 9th year, about 90; at puberty, 80; from manhood to the beginning of decadence in life, 65 to 75, and in old age the pulse-rate will run from 55 to 65 per minute. In regard to this statement of the average rate, our most accurate observers do not all agree; but, in my opinion, these figures may be relied upon as being as nearly correct as will be found necessary for all practical purposes, though in many individuals, and especially in those who are peculiarly idiosyncratic, and in some temperaments, a great range of difference may be looked for and expected; and under such circumstances, the range may be, in the adult, from 100 down to 40 without any apparent manifestations of disease. The fact is, that the vagaries of the heart's action, under like circumstances, with different individuals is, sometimes, utterly unaccountable. In the adult sex seems to exercise

some difference in the pulse-rate, 80 to 85 being the average for the female, and 60 to 70 for the male. Those persons, of either sex, of nervous temperament, may be expected to go above these figures, while those of a bilious, or phlegmatic temperament will range below. The pulse-rate is the greatest when the individual is standing, less frequent while in a sitting posture, and the lowest when the person is in a recumbent position, or in a tranquil sleep. Any exercise, whether mental or physical, that calls for a greater blood supply, will increase both the frequency and force of the heart's action, such as violent exercise, immoderate passion, or great, good and unexpected news; while a mental or physical shock, coming suddenly, without premonition, will lessen the frequency and force of the contractions of the heart; and even death has been known to occur under these circumstances, from the failure of cardiac action; not because of any fatal organic lesion but wholly from mental shock caused from sudden horror, or other mental impression.

I now speak of these circumstances as affecting cardiac action while all the organic functions are in a physiological condition; because there is no other method of eliciting the state of the general system, nor of local disease, excepting it be by means of comparison between the cardiac movements in health and disease.

The vagaries of the movements of the heart, under different conditions, is truly wonderful, and hence it requires acute discernment, and local discrimination in the various phases of disease, to ascertain from the cardiac sounds and impulse the actual condition of the vital forces that are keeping alive and in working order, the functions of the economy. But, when we come to compare the different characters of the pulse, induced by the force or frequency, or both, by the impulse given to the blood by the heart's action, we may see more clearly the indications for treatment during the progress of disease, organic or general.

The frequent or rapid pulse has relation to the number of the pulsations or contractions of the heart per minute, without regard to its force or other qualities.

A quick pulse has regard to the suddenness of the impulse given by an irritated heart, and the comparative brevity of time



the impulse lasts upon the examining fingers, denoting the small quantity of blood passing through the artery at each impulse at a given time, and has no relation to the frequency of the contraction of the ventricles.

A full pulse has relation to and denotes the quantity of blood passing through the artery in a given time, and has relation to its volume only.

A tense or hard pulse denotes the force of the blood pressure; and such a pulse may be full, tense and frequent, or small, hard and frequent, or it may be full and tense, or small and tense, without being frequent, and be recognized, in either case, by the difficulty we experience of compressing the artery so as to prevent the blood from passing under the fingers during examination.

A full, round, soft pulse, indicates, if regular, a normal condition of both the heart and arteries, and a general healthy condition of all the organic functions of the economy.

A small, soft or feeble pulse denotes either great prostration of the vital forces, and a consequent feeble systole of the heart, or it gives us due and timely notice of dilatation of the left ventricle, and a consequent inability to propel the blood through its channels with its accustomed force. Again, great prostration of the vital functions of the body and dilatation of the ventricles of the heart may co-exist, and each condition being, to some extent at least, dependent on the other, gives us ample reasons to show why the pulse should be soft, the tension nil, and the impulse feeble.

An intermittent pulse is one where the impulse given to the blood by the contraction of the ventricles, does not extend to the extremities; or it may be an entire omission of the ventricles to contract, but this occurrence is very rare. The prime cause of an intermitting pulse, usually, being the feebleness of the systole of the heart, from whatever cause this condition may have been derived.

An irregular pulse has no relation to an intermittent, and yet, both may be present at the same time and in the same individual. Irregularity simply indicates the condition of the cardiac action, that it is slow for a few beats, and then frequent for

an equal or greater number of beats; and this condition of the heart's action always indicates a low condition of vitality, or irritation of the nerve centers that preside over the cardiac movements, or, perhaps, both conditions may exist at the same time; but in either case there would be abundant cause for such irregularity.

There are several other varieties of pulse of which authors speak, but the distinctions that they make are drawn a little too fine for any practical purpose to the general practitioner, and consequently I shall relegate them to the expert or connoisseur in such matters, who have more time, taste and opportunity to investigate the pathological conditions which give rise to the more intricate manifestations of the heart's action, and its effect upon the pulse, which induces its most intricate variations.

There is one thing, however, in this connection, that I would impress upon the minds of the younger members of the profession, and that is, when you perceive any abnormal action, or sounds of the heart, never leave your patient till you have made a thorough stethoscopic investigation of its sounds, and have pictured to yourself, in your mind's eye, the relations existing between such condition and any functional derangement or organic disease, or lesion, that you may have under investigation. The facts are that we are all too much inclined to be in a hurry, and disposed to jump at conclusions, when we have only made desultory or casual examinations, and leave to nature—the greatest physician of us all—the repairs that we should have assisted her in bringing to a successful termination. We should be more methodical and deliberate in our investigations and aim to do nothing until we have made an investigation of all points connected with the case, and can give a good and sufficient reason for what we propose to do, under the prevailing conditions connected with the case. In many of the peculiarities of the pulse, the cause may be looked for in the heart itself, it being as subject to disease and functional irregularities as any other organ of the body, and the derangement, or disease, of this great central organ, may be regarded as a greater cause for alarm than any other viscus contained in either of the great cavities. The great and important reason for this is, that every other organ and

tissue of the body must and does receive its nourishment from the heart by oxidation through the blood, which is the common carrier of these vital agents. The condition of the heart, therefore, whether diseased or in a healthy state, is one of the principle factors in the production of whatever character of pulse we may meet; and yet, the condition of the great nerve centers, or at least, that portion of them that presides over the nutrition and motion of the heart, may have such an influence over the pulsations as to make it very difficult to diagnose the cause of such irregularities. Then, again, the pulse may be full and tense, or small and tense, when there is hypertrophy of the left ventricle, and yet there may be neither a plethoric nor a sthenic condition of the system. Indeed, I have known old men, who had hypertrophy of the heart to have a tense pulse to within a few hours of their death.

There are other conditions, however, that are either local or general, independent of the pulse, that may enable us to make a correct diagnosis in any case, but we would naturally, even then, turn our attention to the pulse to ascertain the general condition of the system and its vital possibilities. If the disease is sthenic, we will find a frequent, round, full, tense pulse, and the temperature above normal; in this case, the indications would be evacuants, sedatives, refrigerants, etc. But there may be a sthenic condition and yet a small, corded pulse, which would be most likely to occur in congestion of the lungs when the capillaries refuse to let the blood through, either from contraction or engorgement from relaxation, to the left side of the heart: the right auricle and ventricle becoming oppressed from engorgement with blood from the general system, and on account of the constriction or engorgement of the pulmonary capillaries, the heart labors in vain to supply the general want. In such case we would have a small, soft, frequent pulse, and a mistake in diagnosis, in this case, might be a fatal error; because, instead of giving stimulants, as the pulse would indicate, the lancet should be used to relieve the engorgement of the right heart, and saline cathartics to lessen the engorgement of the portal circulation, and at the same time lessen hepatic embarrassment from blood pressure, caused by the inability of the heart to get rid of

its apoplectic condition, caused by the engorgement of the capillaries of the lungs. Again, we may have a feeble, small, soft pulse, that may be occasioned from dilatation of the left ventricle, which, on a casual examination, would induce us to administer alcoholic stimulants, and then leave our patient to the tender care of uncertainties, under the conviction that we were doing all that could be done in the case, while, if we had made a more critical examination, we would have learned that, in addition to what we had ordered, we should have given digitalis with great satisfaction to ourselves and obvious advantage to our patient; the reason for which is too obvious to us all for further comment. Then, again, there are cardiac valvular lesions that interfere with the normal impulse given to the blood by the contraction of the ventricles, which should be taken into considerate investigation. When we find the pulse is not normal, which may be ascertained pretty accurately by the different sounds transmitted through the chest-walls, and through the current of blood in its transmission through the arteries, we should be on our guard lest we should be taken unawares. For instance: In case of inefficiency of the tricusped valves, we not only hear a peculiar regurgitant murmur, but we see a retrograde impulse given to the blood in the external jugular veins, that may be not only seen, but it may be felt; also, in case of perforation or sloughing of the semi-lunar valves from ulceration, or other cause, the second sound of the heart becomes indistinct, or imperceptible on account of the blood being thrown back into the ventricles by the elasticity of the arterial membranes. This condition would not only signify a feeble pulse, but a vibrating one, and an indistinct impulse from the systole of the heart.

I throw out these suggestions, gentlemen—by no means complete or exhaustive—on this subject, not because there is anything new or novel in them, but to call the attention of the younger members of the profession to the importance of this subject, and if I should succeed in this, I will be amply repaid for the thought and care I have given this subject.

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Subscribe for the PEORIA MEDICAL MONTHLY, a practitioner's journal; \$2.00 per annum.



## TAPE WORM.

BY J. OETTIKER, M. D., PLATTEVILLE, WIS.

Having had excellent success in the cure of the few cases of tape worm which has fallen to my lot to treat, I will give my method of procedure, and would ask those who have trouble in expelling this parasite to give this method a trial.

In the treatment of four cases, the entire worm was brought away in three, at the first attempt; the fourth required a second treatment. I proceed as follows: Have the patient prepare a double handfull of pumpkin seeds—here in the country this is no trouble. I prepare 4 ounces of decoction of fresh pomegranate root bark, by macerating  $2\frac{1}{2}$  ounces of the bark in 8 ounces of water for 24 hours, then gradually simmer down to 4 ounces. I then direct the patient to eat a very light dinner; at supper take half the pumpkin seeds, at breakfast the other half; half an hour after I give one-third of the decoction of bark, giving the remainder in two doses at the same intervals, following this in about two hours by a large dose of castor oil. In case the patient is inclined to constipation, I see that the bowels are well opened before beginning treatment.

This treatment brought away a worm from a party who had received treatment from several physicians during a space of two years.

There is nothing new in the remedies but probably few use the pomegranate and pumpkin seeds together.

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CORRESPONDENCE.

## CASES FROM PRACTICE.

BRENHAM, KAS., Dec. 18, 1885.

*Editor Peoria Medical Monthly:*

Not being overburdened with patients at present, while "holding down a claim," I will give you the outline of a case I attended in Mason County, Ill., during September and October, 1878, asking for comments as to treatment.

A lad of fourteen sustained the fracture of both clavicles at the outer third and of left acromion process. Being somewhat

nonplused at such a combination, was at a loss, nevertheless I applied a double Fox's dressing, and secured a good result, notwithstanding his extreme restlessness.

I can find nothing in Gross, Holmes or Hamilton for the treatment of such fracture, and would ask if there is a better way than I adopted?

Last June was called to see R. D——, aged 40; found him suffering from a dislocation of the left femur at its upper extremity, upward and backward into the iliac fossa. The characteristic shape of the muscles over the hip was fully developed; the knee rested on the opposite limb above the knee; toe inverted touching above the ankle; a great degree of shortening existing.

Dr. Norris, who attended with me, anæsthetized him and I reduced it in a couple of trials, by manipulation alone. By using a protection bandage, there was no further trouble, excepting the day after when I found the bowels fearfully distended, this entirely disappearing on the exhibition of a brisk cathartic.

Moved him eight miles on the fifth day, and at the end of the third week he was moving around on crutches.

W. P. WALKER, M. D.

### MISTAKE CORRECTED.

WILMINGTON, O., Dec. 5, 1885.

*Editor Peoria Medical Monthly:*

Allow me to call your attention to what I believe to be a very grave and dangerous typographical error which occurs in your last issue of the MONTHLY, on page 415 in the formula for headache, according to which you propose to give  $7\frac{1}{2}$  grains of corrosive sublimate (or about that amount) in a day. I suppose the "gr." should be substituted for the "dr." in the formula. To one of experience it would need no warning from me, but it might fall into the hands of one inexperienced in the drug and result in fatal consequences. I am sir,

Yours respectfully,

G. S. HILL, M. D.

## QUININE FOR CHILDREN—SWEATING.

*Editor Peoria Medical Monthly:*

In your journal for November Dr. —, Wisconsin, wants to know the “best method for disguising the taste of quinine, especially for children.”

Let me say that the formula published in the same number of your journal, page 413, or a slight modification of it, I have found as good as any, but I have for a number of years been using, with a great degree of satisfaction for some adults as well as children, the preparation known as “sweet quinine,” manufactured by Stearns, Farr & Co., of New York. It has in my hands, and in those of other I know, proven *very* efficient, is almost absolutely tasteless, and is taken by any child as readily as is Dover’s powder. It must be given in about one-third larger doses than the ordinary quinine sulphate. I think that if the Doctor will use it a few times he will never again go amongst his little patients without it.

In the same number of the MONTHLY Dr. M., of Illinois, inquires for a remedy for his case of night-sweats. My impression founded on some experience, is that if he will give the child a spoonful of tincture of valerian each night upon going to bed it will soon recover from the vexatious complaint.

Your other correspondent’s query in regard to the use of antipyrin I, too, would like to see answered by some one practically familiar with its use, for I know nothing of it myself.

Respectfully,

MEDICO.

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EXCESSIVE SWEATING.

*Editor Peoria Medical Monthly:*

In the last number of the MONTHLY Dr. M., of Illinois, inquires for suggestions as to the treatment of a case of night-sweating in a child. In order to try and aid the Doctor I will say that I some time ago had a couple of similar cases, and, reasoning from the analogy between them and cases of sweating occurring with women at the change of life, I administered bromide of potassum with the happiest of results. I have found

nothing equal to the bromide in such manifestations at the climacteric, where the patient was otherwise in apparent health, and in my limited experience some cases in children, seem to be due to a similar condition of the vaso-motor nervous system, a condition which seems to be controlled, and in time removed, by the bromides.

Very truly,

G.

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### CÆCAL OBSTRUCTIONS.

*Editor Peoria Medical Monthly:*

*The New York Medical Journal*, November 7, 1885, gives an account of the sickness, treatment, and death of James Lawrence Little, M. D. I have recently had two cases similar in symptoms which I treated successfully, and because I treated them successfully, and because both patients had been unsuccessfully treated by physicians before I attended them, therefore I give a brief account of my treatment, so that others may have success in relieving the same kind of complaints. The complaint was caused by a collection of hardened fæces in the cæcum, oppressing the ilio-cæcal valve so that the patients had not had a movement of the bowels for days, and I could even feel a lump or swelling in the region of the cæcum, and the patients were much distressed. I immediately had them lay on their right side, and a large injection of soap suds given to them so that the fluid would gravitate to the cæcum and ilio-cæcal valve to soften the hardened fæces and had the patients retain it as long as possible and then get up and discharge it. At the same time I gently kneaded the bowels in the right iliac fossa. This mode of procedure I pursued once or twice per day for several days. The proceeding had the immediate effect to bring away considerable of the hardened fæces. I also gave to the patients slippery elm tea for a number of days. The both recovered rapidly and perfectly.

SILAS HUBBARD, M. D.,

Hudson, Ill.



## PECULIAR SKIN AFFECTION.

*Editor Peoria Medical Monthly:*

A year ago various persons in this vicinity suffered from a peculiar eruption of the skin. It was principally confined to men, and was very difficult to control. It was evidently not the ordinary itching eruption, inasmuch as the bacilla could not be detected by a high-power microscope. I used for it, sulphur, carbolic acid, and balsam Peru with marked success. Again, during the past few weeks, I have had several cases for treatment. It is evidently the same, though in the present instances more distinctly postular. I now observe that it is found only in those of a weak constitution. This pustular eruption seems to be identical with that arising from a bed-bug bite. The first one I saw I looked for a bed-bug. At this the lady became indignant, and informed me, in terms certainly as forcible as elegant, that there were none such in the house.

Before long, I had a patient in my own house. The bed-bug theory is now, of course, out of the question. And as I can in this instance make a very close examination, I must confess I am unable to give the cause. I am not willing to shove it into the locust's shoes, for it is already sufficiently punished. As a second treatment I use a luke-warm solution of bicarb., sodium and iodide of potassium, following a mild cathartic.

C. A. WILDE, M. D.

Buckskin, Ind., July 18th.

P. S.—Since writing you the letter I have recognized the insect which undoubtedly caused the eruption. It is the *chiggra* or harvest bug. It must be a relation of the bed-bug.

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EXCESSIVE SWEATING.

PALMYRA, ILL., Dec. 17, 1885.

*Editor Peoria Medical Monthly:*

For Dr. M.'s case of sweating I would advise alcohol in full doses, until relieved; then follow with—

R. Con. tr. avena Sativ.

Celerina.

Elix. Simp.,

aa

2 ounces.

M.

Sig.—Teaspoonful every six hours.

If you suspect phthisis give tr. verat. virid. in two drop doses twice a day, being careful to watch results.

C.

## SOCIETY TRANSACTIONS.

## CHICAGO MEDICAL SOCIETY.

Stated Meeting, November 16th, 1885. The President, C. T. Parkes, M. D., in the chair.

"A Report Embodying Two Hundred Cases of Tonsilitis," was the title of a paper read by Dr. J. M. G. Carter, of Waukegan, Illinois.

After detailing the treatments which had been employed in the cases, the author advanced the theory that since the great majority of the cases occurred during March, April and May, when northeast winds prevailed, carrying landward more moisture from Lake Michigan, these winds must be one of the casual factors in the production of tonsilitis. Also the test from ozone during these months showed a greater percentage of ozone in the atmosphere. Another fact was noticed, that a great many cases occurred in rheumatic patients. The author was of the opinion that the epidemic of cases detailed was due to the damp northeast winds, containing an excess of ozone, and to unusually disturbed electrical conditions of the atmosphere. The author grouped the two hundred cases, without classifying them, into cases of simple, diphtheritic or scarlatinous tonsilitis. He mentioned, however, the fact that cases of simple tonsilitis were often accompanied or followed by attacks of diphtheria or scarlet fever among other members of the family.

## DISCUSSION.

Dr. F. O. Stockton said: We have tonsilitis in nearly all the eruptive fevers, usually following, and occasionally preceding them. The author refers to cases having diphtheritic patches of the tonsils: I think he has confounded these diphtheritic cases with what we specialists call follicular tonsilitis. It is not a diphtheritic condition at all, but resembles it very greatly, so that in a different diagnosis these cases are very often confounded. In regard to the temperature going up to 104, it is my experience, and that of authorities such as Cohen, Bosworth and Robinson, that it ranges from 102 to 103, seldom more than 103, usually 102. In the treatment of tonsilitis I have never found a gargle effective. In diphtheria or acute tonsilitis you can give

chloride of potash, or any other drug, but where a man has a pain in the angle of his jaw and a throat so sore he cannot swallow, if you can get him to gargle you can do more than I can. Ice held in the mouth until it dissolves is good, also powder or tincture of guaiac and tincture of aconite internally, but never give more than three doses of aconite in one day. Occasionally, if you see a case is going on to suppuration, use hot applications externally and internally in the way of steam, otherwise never use hot applications. My idea is that heat promotes congestion more than cold, and my experience is that where cases are treated, some with cold and others with hot applications, that the cold in connection with other treatment, guaiac and tincture of aconite, is most successful. We ought to settle this question of tonsilitis. What is acute tonsilitis, and is there such a thing as acute tonsilitis? To me it is a misnomer. The abscess seldom forms in the tonsil, it is behind it in the loose connective tissue; and in opening it we cut behind or above the tonsil.

Dr. C. W. Earle said: I would like to ask Dr. Carter if there was any appearance of contagion in any of the cases?

Dr. J. M. G. Carter said: Frequently the disease will attack everybody in the family, old and young, and just as frequently but one or two in the family have the disease. It sometimes appears to be contagious.

D. G. C. Paoli said: Tonsilitis is a very common disease in Chicago, especially among children. It is certain that there are different degrees of tonsilitis: there are light cases in which very little medicine is required, and again there are strumous children who are very susceptible to the changes of weather, and in inclement weather get wet and have tonsilitis. In some cases one tonsil is affected, in others both, or the pharynx. There are grave cases that cannot be cured in one week, or two, cases that develop into hypertrophy of the tonsils. In regard to treatment: a light case does not require ice, and a person with malignant scarlatina with tonsils affected would take cold from the application of ice. We should discriminate, and in malignant cases where the tonsils are inflamed, should be careful about applying ice. In the use of aconite, with children, we should be very careful, as in fever it diminishes the circulation, and I would not recommend its general use unless you can see the patient two or

three times a day and watch the effect of the aconite. A simple thing to use is a little potash with tincture of iodine. In scarlatina complicated with diphtheria it is better to use very little medicine. I have nothing against chlorate of potash, however I read a very interesting paper by a professor in New York, his name I do not now remember, who says that observation has shown that chlorate of potash has often produced nephritis, and I think great care should be taken in its use.

Dr. R. Tilley said: One of the points brought forward by the author is the use of kerosene. I remember that Besnier, a professor of skin diseases in Paris, says that kerosene is used extensively by the laity, but he regards it as a dangerous remedy in the hands of people generally, and a very inefficient one: he was speaking, it is true, of the treatment of itch. I protest against the use of the terms ozone and electrical conditions of the atmosphere; we know practically nothing about either.

Dr. J. M. G. Carter said that he was obliged to leave in order to catch the train for Waukegan, and expressed regret that he could not remain and reply to the criticisms upon his paper.

Dr. W. E. Quine said: An interesting feature of the experience embodied in the paper is the obvious failure of the writer to differentiate infectious from non-infectious tonsilitis. I presume it is a matter of familiar observation to all who have been engaged in the practice of medicine that many cases of follicular tonsilitis occur which baffle the judgment of the most experienced physician to determine with precision whether they are infectious or non-infectious. I have often seen in my practice cases of this kind. Often one member of the family, probably the first one attacked, exhibits plainly marked features of simple follicular tonsilitis, and those of the family who sicken afterwards exhibit the phenomena of diphtheria, or less frequently, scarlatina. The text-books do not give a reliable guide to diagnosis, and if any of my colleagues know of means by which cases of this kind can be differentiated with certainty we would like to know them.

One gentleman has alluded to the opinion of an eminent professor in New York; I remember that Jacobi, who is perhaps the person referred to, in a recent article maintains very vigorously



that many cases of so-called tonsilitis are in reality immature cases of diphtheria, and he stoutly maintains that there are many cases of diphtheria never having patches in the throat, and where the patient walks on the street and communicates the disease freely to those with whom he comes in contact.

Dr. Sarah Hackett Stevenson said: Last February I was called to see a lady who had frequently suffered from tonsilitis. She was "subject to quinsy." I suggested that her child should not be kept in the same room with her as the case seemed more than ordinarily violent, and gave the usual treatment for quinsy; the disease went on to suppuration. I was called out of the city after one of the tonsils had discharged, and during my absence, about five days, her child was attacked with malignant scarlet fever, and died before my return. This is the first case in which I ever suspected that a benign form of tonsilitis might reproduce a malignant form. Since then I have watched all cases, however simple they may seem.

Dr. C. T. Fenn said: I think we should all take an interest in this work, especially in the most practical suggestions of Dr. Earle. The fact is, that to regard these cases all as malignant, is to be on the safe side. A case of simple tonsilitis has a tendency to develop into diphtheria. I protest against the folly of attempting to distinguish between mild and simple cases of tonsilitis and diphtheria. In regard to treatment, I have no use for gargles or washes; I will not force open the mouth of a child and cause it to cry, but steadily and persistently, every fifteen minutes, I will give such medicines as the child will pass over the tonsils when swallowing.

Dr. J. S. Knox said: I regret that the paper is so general, the author evidently grouping together a variety of cases of tonsilitis of different classes. There is undoubtedly an inflammation of the tonsils due to eruptive diseases, such as small-pox and scarlet fever, and there is a tonsilitis which is purely catarrhal, and another which is purely due to diathesis and which is rheumatic or syphilitic. The treatment differs accordingly. I think there is an error as to the value of chlorate of potash: better results will be obtained from the use of bicarbonate of potash, the value of the drug lying in the fact that it is a potash salt, and I think that the bicarbonate of soda would be still more efficient. Where the hyposulphite of soda would do good, the salicylate would do more.

Dr. J. J. M. Angear said: It seems to me that if we remember that there is such a thing as resistance, the absence of which is susceptibility, it will explain some, if not all of these difficulties. We can readily imagine a robust, healthy child with strong resistance to morbid influences, and especially that of diphtheria, on exposure, would have simple tonsilitis (abortive diphtheria); but suppose that his brother, with strong susceptibility, is exposed to the same morbid influences, he will develop a case of undoubted diphtheria.

In diphtheria, we have an inflammation with fibrinous exudation which breaks down the mucous cells and forms the diphtheritic patch; this furnishes a nidus for the micro-organisms, which go on secreting or fermenting their peculiar virus, the absorption of which contaminates the whole body, and now we have a constitutional disease. Will not this explain a large number, if not all, of those cases where four or five children in a family are taken apparently with simple tonsilitis, and some one child that has not their resistance is attacked with undoubted diphtheria. In this house we have tonsilitis, and our neighbor severe diphtheria. By remembering these pathological facts, we shall see that it is, or it may be, all the same morbid influence here and yonder; here, recovery in a few days; there, death in a few hours.

Dr. F. O. Stockton said: In acute tonsilitis I think it will be found that ice is the proper treatment in the first stage, before suppuration has begun. It is very seldom that pus is located in the tonsil, it is behind the tonsil. With regard to a differential diagnosis between diphtheria and tonsilitis, there is almost always in diphtheria a regular graded rise in the temperature; in acute tonsilitis, so-called, or follicular, the temperature is not regular, it rises at a jump, the attack comes on suddenly, begins with a chill immediately followed by fever; in diphtheria there is a gradual rise, going up one day, dropping the next. I think if we took a record of given cases of diphtheria and tonsilitis, we would find that a regular rise in temperature in diphtheria occurs as in the essential fevers.

## PERISCOPE AND ABSTRACT.

## COMPLETE INVERSION OF THE UTERUS FOLLOWING PARTURITION.

Henry E. Crampton, M. D., of New York, concludes a very interesting and exhaustive paper on the above subject in the November number of the *American Journal of Obstetrics*, from which we take the following as of special, practical importance to every man or woman engaged in obstetric practice:

In recent inversion we have constant hemorrhage, more or less profuse. Shock is rarely absent. Conjoined with these there is a peculiar anxious expression and manner. The patient cannot keep quiet, but tosses fretfully about the bed, and screams with pain during examination. Every movement shows how profoundly the whole nervous system sympathizes with the terrible dislocation.

A vaginal examination makes the diagnosis certain.

If, "by reason of strength," she rallies from this state and gets about, she suffers from frequent hemorrhage, more severe at the menstrual period and after weaning. There is progressive anæmia, with leucorrhœa, frequent and exhausting faintness. Life is rendered miserable.

Crosse relates a horrible instance of mistaken diagnosis which I will briefly summarize:

The patient had borne eight children. The last two labors had been delayed by adherent placenta. In her ninth confinement, she was attended by a licentiate of Apothecaries' Company who, finding some difficulty in taking away the after-birth, proceeded to remove it by force. "He soon broke the funis and subsequently removed portions of the placenta, and continuing his operations, causing most excruciating sufferings to the patient, he, at length, and by great perseverance, removed a large mass which the woman present thought looked like a liver or an enormous after-birth. This he took away in a vessel to his own house, situated near by, and soon returned; but before he arrived the patient was dead. The next day, he represented that he had removed a large tumor or polypus, weighing three pounds.

"Strong suspicions of malpractice having been entertained, a *post-mortem* examination was made, Dr. Crosse himself assisting, when it was demonstrated that the entire uterus, with its appendages, all the large intestines, except the lowest thirteen inches, nearly all the great omentum, the caput coli and two or three feet of the ileum next above it, had been forcibly removed, per vaginam, in this most unparalleled case." The result of the inquest was a verdict of manslaughter. The doctor was subsequently tried, but escaped conviction.

Chronic inversion has been mistaken for polypus, but the error can be corrected by a very simple procedure. Two fingers of one hand should be introduced into the rectum, while, at the same time, a sound is passed through the urethra. If these meet above the tumor, the uterine body is absent, and inversion must have taken place.

Hemorrhage is the most constant symptom. It is often profuse and alarming, and frequently the sole cause of death. In four cases only is it set down as slight, but in one of these death took place in half an hour from collapse and shock. In one instance it was entirely absent: the patient recovered. Shock was always marked. This peculiar indefinable condition, which we all recognize but cannot locate, is the great danger in uterine inversion. This will not seem strange if we think for a moment of the serious dislocation of the most sensitive tissues of the human body which must ensue from this accident. The ovaries, the Fallopian tubes, and the uterine ligaments are dragged down into the pelvis, while the sensitive and bleeding endometrium itself is exposed. Death ensues in about twenty per cent. of recent inversions, whatever the treatment.

In concluding his article, Dr. Crampton then submits the following propositions:

1. Inversion of the uterus is preceded by paresis of some portion of the uterine muscle (not necessarily of the placental site), caused either by too frequent child-bearing, tedious labor, previous miscarriages, traumatism (blows upon the abdomen received during pregnancy or labor), emotional excitement (notably in primiparæ), or too rapid labor. It is a pure neurosis in its inception. Traction upon the cord may induce prolapsus; if severe, procidentia. It will *never alone* produce inversion, but may facilitate it, if paresis is present.

2. It is more apt to occur in first than in subsequent deliveries.

3. This liability in primiparæ is due to the peculiar emotional excitement preceding and associated with a first labor reflected upon the exhausted uterine muscles for the first time called into unusual action. (Eight out of ten of all cases of puerperal eclampsia occur in primiparæ for analogous reasons.) Given a slight degree of depression of any portion of the uterine body, and the natural rigorous contractions of the uterus in a first labor become a source of increased danger.

4. In a great majority of cases of recent inversion, firm and persistent pressure (under anæsthesia) upon any portion of the inverted organ will serve to reposit it.



5. In chronic inversion gentle, graduated, and long-continued pressure, either manual or instrumental, or both combined, has proved the most successful treatment. Forcible taxis is not devoid of danger. Extirpation is a last resort.

6. Chronic inversion would be rarely found if every physician adopted the invariable custom of making repeated and careful vaginal examinations after every labor.

7. The prophylactic treatment of uterine inversion is obviously the same as that required for the prevention of puerperal eclampsia.

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### BILROTH'S VIEWS ON ANTISEPTICS.

Bilroth writes the following on antiseptics:

1. Iodoform is the safest and most effective of all manageable antiseptics. 2. Moss, wood, turf, mould, and oakum are useful when there are discharges from the wound. 3. Corrosive sublimate in dilute solution is practically inert as an antiseptic to wounds, and renders the patient and surgeon alike liable to mercurial poisoning. 4. Carbolic acid, which is known to be dangerous in strong solutions, is, in very weak ones, as good for wound irrigation as clean water, but probably no better.—*Canada Lancet*.

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### THE ACTION OF DISINFECTANTS ON MICRO-ZOOIDS.

In the *Sanitarian* for December we find an abstract of a paper read before the medical officers of Health Society, March 20, 1885, and clip therefrom the concluding paragraph, as follows:

Turning to the practical aspect of the question, the author summarized the general conclusion to be drawn from these researches. Disinfectants, when they are not destructive agents, act as poisons: they poison the microzoid in a manner not essentially different from the lethal poisoning of a higher life form, and this is the reason why such poisonous substances as corrosive sublimate, carbolic acid, and chlorine are most to be relied upon. It was evident that, to perfectly disinfect, the element of lime must not be disregarded: to receive the specific excreta into a strong solution of sulphate of iron or of carbolic acid, and then within a few minutes cast the excreta into a drain, could only superficially disinfect, and such excreta might in many obvious ways again become dangerous. He considered that the best and most efficient way to disinfect a room after disease was:

First, to make it as much as possible like an hermetically sealed box, and in this box to evolve chlorine: three pounds of chloride of lime and three pounds of hydrochloric acid for every thousand cubic feet of space. The chloride of lime was to be divided into several distinct parts in deep vessels, and to be placed as high in the room as possible; the hydrochloric acid was to be mixed with the chloride of lime gradually, in the manner described by Fischer and Proskaner. The room was to be kept closed for twenty-four hours. Secondly, all things in the room capable of being submitted to a moist heat were taken away to a suitable apparatus. Thirdly, the floor was to be washed with a solution corrosive sublimate (1 to 1,000). The principles of this process had been carried out in the parish of Marylebone for more than a year, and the author considered the method the best at present known.

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### DISGUIISING QUININE.

The *Canada Lancet* says "one and a half grains of tannin will neutralize the bitterness without changing the action of ten grains of quinine," and adds: "The intense bitterness of the drug renders it almost impossible to administer it to children in its natural state."

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### THE EPIDEMIC ZYMOTIC DISEASES OF ANIMALS AND HOW THEY ARE COMMUNICATED TO MAN.

In the *Canada Lancet* for December we find an annual address on the above subject, read before the Medico-Chirurgical Society, Ottawa, by Dr. J. A. Grant, of London, which contains so much that is of interest and value not to be found succinctly stated elsewhere that we give the salient points thereof, as follows:

"The subject," says the Doctor, "is one of vast importance to our common country, irrespective of its scientific aspect, inasmuch as it involves millions in our live stock. Endemic and epidemic diseases are not alone confined to the human species. The analogy in manifestation is so close that they are designated by the same names.

"The next cause of these diseases is supposed in the animal organization to act like a ferment, hence the term 'zymotic.' According to the most recent inquiries the generation of 'organic germs' originate in the individual, or by fermentation in the diseased excretions of organism, and thus transmitted through various media from body to body, at sensible and insensible distances."

"Diseases in animals are of two classes, the *exotic* or *uncommon*, and the *indigenous* or *common*. Of the first class we have *small-pox in sheep and birds*, pleuro-pneumonia of cattle, rinderpest, malignant diseases of the generative organs of the horse kind, malignant cholera of animals, aphthous fever, known as foot and mouth disease. Of the second class, or indigenous diseases, belong glanders, rabies, contagious foot rot, tuberculosis, malignant asthma, hog cholera, or intestinal fever of swine, influenza, strangles, canine distemper, and horse pox, seen in the cow, goat, and pig. In each of these zymotic influence is at work as in development of disease in our own species. Impurity of air, soil and water produce these diseases, in both milk and meat, thus influencing the human family and spreading the germs of a disease of a most serious character.

"Rinderpest, or Russian cattle plague, is a most contagious disease amongst animals of the same species. It is characterized by a congested state of the mucous membrane of stomach and bowels, associated with a high temperature and extensive desquamation of both skin and mucous membrane.

"Foot and mouth disease is a contagious eruptive disease, confined chiefly to cloven-footed animals, but has been known to extend to man. It is ushered in by a rise in temperature and general feeling of discomfort, and within a day or two followed by large blisters on the mucous membrane of the mouth, tongue, fauces, udders, and the parts in and about the clefts of the hoofs. Milk from such diseased animals is often carried to individuals, who in fact most frequently come in for a share of the diseased influence. Soreness and otherwise unaccountable lameness in cattle is a most significant indication, when associated with an aphthous state of tongue or fauces. Thorough disinfection is here necessary, and ablution with carbolic acid lotion, with isolation for ten or fifteen days after disappearance of the disease.

"Epizoo, or epizooty, known as influenza or horse epidemic, has extended at same time to man and beast. Absolute quarantine is the best remedy.

"*Intestinal fever of swine*, misnamed *hog cholera*, is attended by congestion, exudation, blood extravasation in the mucous membrane of stomach and bowels, by general heat, and redness of the surface, and by the appearance on the skin of spots and blotches of a scarlet, purple or black color. It is said to be infectious. It needs further investigation.

Pork as an article of diet makes the diseases of the hog play an important part in relation to public health. Of the parasites which infest the flesh the trichina and the *cysticercus cellulosa* give the most trouble to man. The former taking up its abode in the muscles, and the latter producing the tape-worm. Through cooking will, in either case, prevent disastrous consequences.

"Glanders, or farcy, requires more than a passing notice from the fact of its fatality when communicated to man from the horse. Its chief specific peculiarities are its inflammatory lesions of the *nasal* and *respiratory* mucous membranes, lymphatic vessels and glands, marked constitutional depression, and frequently accompanied with a pustular cutaneous eruption. Glanders in man is very rare. It is always communicated by direct inoculation of virus from the diseased animal. Average duration about sixteen days. The wound through which the poison is admitted becomes inflamed, tense, painful, and usually has an erysipelatous circumference. The ulcer enlarges, presents a chancroid aspect, discharging sanious, offensive matter, and the lymphatic vessels around present a knotted, cord-like, irregularity, modulated condition, known in man as *farcy buds*. According to Virchow, resolution and absorption occasionally take place, but more frequently abscesses form and constitutional symptoms indicating a low type. Within the first or second day of this disease (and sometimes longer), scattering collections of red spots appear on the skin, small, and resembling flea bites: subsequently they become papular, and elevated above the skin like small shot, and assume a yellow color. The mucous membranes become affected, particularly that of the nose, with inflammation and ulceration. The debilitating character of this disease indicates a stimulating, soothing and supporting treatment. Inhalation of iodine and carbolic acid are strongly recommended, and thorough syringing of the nose with Condyl's fluid (solution) carbolic acid lotion, or iodized water."

Dr. Grant then reverts to the fact of the production of tubercular disease by feeding animals on tubercular matter, according to the experiments of Dr. Bell, of New York, and others, and the promotion of typhoid fever by impure milk. He thinks that much good may be accomplished by interesting physicians more deeply in this matter. According to Dr. Bowditch there are more than "two hundred thousand human beings slaughtered annually in the United States by preventable diseases."

"As to disease in animals, the members of our profession hold great power in their own hands." The facts render it reasonable that there should be some degree of inspection as to both milk and meat, by the proper sanitary authorities.

The country practitioner, especially, has it in his power to contribute to science many a fact connected with the matters above referred to, and possibly in time define the exact cause of various diseases of zymotic character, originating in animals and communicated to man in various modified forms.



## TREATMENT OF DIPHTHERIA.

On November 25, 1885, Professor Joseph E. Winters read before the Section of Obstetrics and Diseases of Women and Children a paper, very exhaustive in character, on the above subject. The same was published in the *Medical Record* for December, and from his remarks on treatment we take the following sensible observations:

"The treatment of diphtheria is far from having reached that unity that might have been expected from the attention which has been devoted to its consideration. The number of remedies to which physicians are continually having recourse proves the efficiency of the greater number of them. Some remedies which have recently been highly recommended, if used as unsparingly as their advocates directed, would certainly be injurious, while others have been tried and found to be useless. If we study the death-rate of this disease, we must confess that, up to the present time we have not, on the whole, been very successful with any mode of treatment. It is easy to be deceived in regard to the usefulness of a remedy employed against diphtheria, for some cases will do well with very little treatment, provided they receive good care: on the other hand, where a case or a number of cases are not influenced, or at least not favorably affected by the treatment, we are too prone to tell the parents that it is a case of unusual virulency, or one of malignancy, instead of examining into our comprehension of the case; and our treatment of it, and admitting that the cause of failure to cure lay here. True, there are cases of diphtheria of great malignancy, but if we were to adopt a system of rational therapeutics to meet the indications of each individual case, based on well-considered physiological and pathological data, we would hear less about malignant diphtheria.

"We are too apt to be wedded to particular methods of treatment, and believe in their excellence, without giving due regard to the indications of cure furnished by the epidemic character of the disease, the constitution and diathesis of the patient, the character of the symptoms, the disordered functions of the important organs of secretion and excretion; the modes and paths of elimination of the virus of the disease; the disposition to certain complications; the prevalence of other epidemic diseases which might modify its course; and the season of the year. Each and all of these conditions should be our chief guides, as in every case much depends on the precision with which the exact *nature* of the case, and the state of the vital powers are ascertained. The mode of treatment in vogue has for its object (according to its exponents) to attack the poison or germ of the disease, as an entity, and destroy it, leaving out of view every other consideration.

"Physicians in search for such a specific are distracted from a rational treatment. These experiments have doubtless killed more patients than germs."

"After carefully considering the results of mercurial treatment thus far adduced, as well as other features in the management of the disease, the author continues:

"From carefully weighing these facts, I have come to regard elimination of the poison as the first indication of cure in diphtheria. By this management we promote the expulsion of the morbid matter, and we are able to use, with decided benefit, drugs directed against the disease, such as iron, quinine, etc.; but the use of these drugs from the outset in cases of marked febrile disturbance, without preparatory treatment, seems to aggravate the symptoms and to less thoroughly control the disease. For the purpose of eliminating the poison so far as possible by the throat, intestines, skin, and kidneys, have recourse to mild purgation, simply sufficient to excite the activity of the glands of the intestinal tract, triturated calomel in small doses being the best for this: put poultices to the neck to excite the activity of the mucous glands of the throat: powdered ipecacuanha compound, as a sedative, diaphoretic, diuretic, or a hot foot-bath, according to indications. Of course this plan is not to be adopted indiscriminately, but our treatment must be modeled in accordance with the degree and acuteness of the inflammation, and an accurate estimate of the vital individuality of the patient."

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### DOCTOR'S BILLS.

The *Medical Record* of recent date says that the reason the doctor's bills are so often impaired is that he fails to make a seasonable effort to collect them. This is especially the case with clerks, mechanics and the small trades generally. The bills are left so until they become relatively large, and then it is impossible, nearly, for the "pay as you go" class to liquidate them. Better collect as frequently as the party collects his wages, and thus retain both his esteem and his practice. Excellent advice, we think.

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### ANOTHER INCOMPATIBLE.

Chloral hydrate, mixed with bromide of potassium in an alcoholic or hydro-alcoholic solution, in the presence of sugar or syrup will form, at first, a milky mixture, and, upon standing, separate into two layers. The supernatant layer will consist of

a light straw colored liquid containing chloral alcoholate. The dense liquid below will consist of the bromide of potassium of a light color. Prof. F. H. Markoe communicated this fact to the Massachusetts State Pharmaceutical Association at their last meeting stating that such a mixture was not a desirable one for the reason that the harsher action of the chloral alcoholate upon the system was objectionable and the comparative immiscibility of the two layers rendered the equal distribution of doses almost an impossibility. Equally objectionable is the mixture of chloral hydrate with sodium bromide, sodium chloride and magnesium sulphate, in strong solutions in the presence of sugar and alcohol, but ammonium chloride, ammonium bromide, potassium nitrate and calcium bromide were entirely compatible with chloral made under similar circumstances.—*Druggists' Journal*.

### COCAINE—NITRIC ACID.

The mixture of cocaine with nitric acid gives a painless escharotic for the removal of moles, deep seated freckles, etc. A formula for its preparation was recently published in the *National Druggist*, which we here give:

R.	Nitric acid (s. q. 1.340),	℥ 1 drachm.	
	Cocaine,	6 grains.	M.

Keep in a small bottle with well fitting stopple for use.

The mole or freckle should be surrounded with a ring of wax to protect the adjacent skin. The end of a glass rod dipped in, and then cautiously applied to the surface of the mole or freckle, the process being repeated once or twice a day, and the unsightly spot has the vitality destroyed without pain, being then easily and effectually removed.—*Druggists' Journal*.

### ANTI-FRECKLE LOTION.

R.	Hydrarg. bichlor,	12 grains.
	Acid hydrochlor, <i>pur.</i> ,	3 drachms.
	Fruct. amygd. amar.,	1½ ounce.
	Glycerin,	1 ounce.
	Tinct. benzoin,	2 drachms.
	Aqua flor. aurant., q. s.	

Dissolve the corrosive sublimate in three ounces of the orange flower water, add the hydropchloric acid, and set aside. Blanch the bitter almonds, and bruise them in a Wedgwood mortar, adding thereto the glycerin, and using the pestle vigorously;

a smooth paste is thus obtained. Then add gradually about nine ounces of the orange flower water, stirring constantly, continuing this operation until a fine, creamy emulsion is the result. Subject this to violent agitation—preferably with the aid of a mechanical egg-whisk—and allow the tincture of benzoin to fall into it the while, drop by drop. Then add the mercurial solution, filter, and make up the whole to the measure of twenty fluid-ounces with more orange flower water.

This preparation is recommended to us by an eminent dermatologist as being invariably efficacious in the treatment of *ephelis*, and always greatly ameliorating *lentigo*, even if it does not entirely decolorize the patches in the latter case. A general whitening of the skin is produced by this lotion, without any irritation. It is as well, however, not to apply it to any abraded surfaces. It has been found far superior in practice to a preparation—which it sometimes resembles—sold at a high price in Paris, under the name of *Lait Antiphelique*.—*Pharmaceutical Record*.

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## HOW TO BUILD UP A MEDICAL SOCIETY.

Our contemporary, the *Journal of the American Medical Association*, in commenting upon an editorial which appeared in the issue of the *Maryland Medical Journal* of October 31, under the above heading, has taken occasion to extend and supplement our remarks in an article which commends itself to all professional readers. There can be no denial of the fact that the manner in which many medical societies are conducted is open to just criticism, and to correction. We have, previously, urged in our columns the importance of correcting some of the abuses which attach to the work done in our local medical societies, such, for example as the careless and indifferent way in which original papers are gotten up, cases reported and specimens exhibited, as also in the impromptu discussions which follow. It must occur to those who attend these society meetings that there is vast room for improvement in the methods of presenting work, and we think, with some effort on the part of each member, an improvement would follow if the reports of these societies were properly prepared and published. The facts that a speaker's remarks will appear for or against him in print will have a double effect; it will encourage him to prepare well before he attempts to speak upon a given subject, or it will enjoin upon him the necessity of keeping silent if he has nothing worthy of remark. Both of these motives are worthy of encouragement. It is far better to kept silent than to talk irrelevantly on any subject. On



the other hand, encouragement should be given to those debaters who come to a meeting prepared to instruct their associates in facts derived from experience or careful study. Indeed, a society which stimulates original work, the development of an individual experience, or the cultivation of the intellectual faculties by diligent study, is doing a valuable work for its membership, just as one which permits membership to run wild in careless statement and in voluble discussions is correspondingly lowering the status of its work and usefulness. There must be a reason for the existence of a society. The subject in view is not purely social or ethical. It seems to us the chief aim is to advance the individual experience, skill and knowledge by the association of ideas, exchange of views, and relation of the experiences of a number of individuals. By co-operation strength is imparted. But this co-operation cannot reach its full measure of strength unless each individual contributes a proportionate share. What one builds up another tears down unless each contributes to the general fund. Hence the society which stimulates no power of strength is directly encouraging its elements of weakness.

Our contemporary offers the following, which we think worthy a place at the conclusion of our remarks:

"One point more. Every physician should consider it his duty to belong to at least one medical society; and his second duty is to attend the meeting. Very many physicians seem to regard membership in a medical society as something accidental or incidental to professional life, rather than a duty which each one owes to himself and his profession. For example, of the forty-three or four hundred regular physicians in Illinois, there are not two thousand who are members of medical societies. This is certainly a very bad showing for members of a 'learned profession.' But the same is true of almost every state in the Union. For one county in Illinois, with twenty-four regular physicians, we learn that 'there is no medical society in this county. The profession is divided.' The 'divided profession' should remember that a society is for the good of the whole, as well as for the benefit of individual members."—*Maryland Med. Journal*.

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### HAY FEVER.

I have used, for two years, during the summer and fall months, the fluid extract and tincture of apocynum for this strange disease. I have not supposed, for the last five or six years, that there was any other way to treat this disease except by partially destroying the mucous membrane of the nose.

I have used apocynum on eleven cases of hay fever last year, and the past summer and fall, with a complete cure in five cases and very great benefit in the other six. Two of the six were only partially benefitted. I used on the last two named a four per cent. solution of muriate of cocaine, 25 drops to 1 ounce of vaseline. Place 20 grains of this mixture in each nostril at bedtime. This application, once every day, gave almost complete relief during the whole twenty-four hours.

The quantity of apocynum used was 30 drops of fluid extract to 4 ounces of water; dose, 1 teaspoonful every three hours.

I would like for some of your readers to use the above preparation, and report what success.—*W. H. Halbert, M. D., in Georgia Ec. Med. Jour.*

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### ABSCESS OF THE LIVER.

I do not propose to enter into an exhaustive discussion of the subject of this paper. Nor do I deem it at all necessary, at this time, to deal too minutely with a subject so generally understood by all physicians and surgeons as abscess of the liver. But in justification, somewhat, for the present detail I will say this, that the inexperienced upon this subject will find very little to console them by searching our standard authorities. They all state that this is a disease that prevails in Egypt, in the East and West Indies; and one author states that it is occasionally seen in boatmen on the Mississippi river.

That it does exist, and exists in sufficient abundance, all up and down our southern water-courses and other places where miasma abounds, is a truth that cannot be questioned, and urges every practitioner to ever be on the alert for hepatic abscesses in all cases of chronic disturbances of this organ.

When we have a well-defined case of abscess of the liver pointing outwardly, we have a case easy of diagnosis, and easily treated; the prognosis of which, with proper treatment, I would always deem favorable. But when the abscess is deeply seated, or pointing internally, the diagnosis is especially difficult, the operative treatment tedious and dangerous, and the percentage of deaths far greater. To distinguish these latter from encysted, or fatty tumors, from hydatids, and, in fact, to distinguish them at all, the aid of the exploring needle must frequently be called into requisition. An intelligent history of the case, however, will reveal enough, with the few physical symptoms that are developed, to almost make certain our diagnosis.

But just here we might ask: What use have we for the diagnosis? When many of our standard authors say that we

must not operate on the deep-seated abscesses at all; that they are sure to die: at the same time confessing that the fluid, left to itself, without an operation, will some day break internally, and by so doing create a certain death.

Bégin, of France, recommends the following operation for deep-seated abscesses of the liver: Make an incision some two or three inches long upon the most prominent part of the swelling, and divide with great caution the layers of the abdominal wall, until the peritoneal linings are reached: raise this carefully with the forceps, nick it and afterwards divide it. Upon reaching the surface of the tumor, the operation must be temporarily arrested, the wound filled with lint and dressed; the patient to remain three or four days for adhesion to take place, after which we open into the abscess with reasonable hopes of success. Several years ago, the Medico-Surgical Society of Alexandria published the statistics of 123 cases, of which only forty-two were operated upon, and eighty-one without an operation. Of the whole number seventy-nine died: in nine the results were not ascertained. It is of interest to note that of those not operated upon eighty per cent. died, and of those who were operated upon only fifty per cent. died. It seems to me, with a limited experience and knowledge of the disease, that the death-rate here cited in both classes of cases is higher than it would be in our country.

A clinical case of much interest has recently come under my observation, a recital of which may be of interest to others.

*Case.*—Saw D. M., colored male, about 30 years of age, on March 2, 1885. He gave the following history: He had been a deck hand on a steamboat and a cotton picker up and down the Mississippi river for the past two years. Had been in bad health for six months: unable for two months to do anything. Was now complaining of gnawing pains in the right side, had frequent rigors, was somewhat dropsical, with enormous enlargement of the liver: jaundiced appearance of the eye, etc., making, in my opinion, a well-defined case of hepatic abscess. To these symptoms were added a dry tongue, tympanites, a temperature of 102, and other symptoms of a slow and low grade of fever. A well-defined tumefaction presented itself in the center of the hepatic region. Being a long distance from home, I determined to try the virtue of my lancet, though I was entirely alone with my patient. Without unnecessary delay I ran my abscess lancet one inch through the adjacent walls, and to my surprise and disappointment failed to reach an abscess. With an exploring needle I found pus and a cavity one inch and a quarter deeper. I now rode a half mile to procure a nurse and assistant to carry out directions. On returning, I made a free incision, whereupon a

stream of sero-purulent fluid began to spurt out with considerable force. I pulled out an ordinary bucket, empty, from under the bed, and in twenty minutes it was filled with this fluid, the latter half of which was thick pus. All told, there could not have been less than eighteen pints of this fluid. I gave him no anæsthetic except a small dose of morphia. Left an alternative to be administered, to be followed by quinine.

On my arrival next day I found my patient worse. Temperature 104.5, some delirium, and symptoms pointing to septic infection. The alternative medicine previously administered had acted well, but the aperture in the side had closed up; no drainage had taken place for ten or twelve hours. On examination, I failed to find the peritoneal adhesions of the day before to the abdominal wall, and think that some effusion into the peritoneal cavity now took place. The adhesions doubtless were of recent date, and not firm enough to resist the pressure of fluid turned in that direction. I had previously bandaged the patient to aid drainage of the pus and to favor adhesions in the cavity, when drained. His face was badly swollen, and every feature was one of anxiety and distress. After carefully probing the wound to the liver, about three and one-half pints of pus were discharged. I saw him an hour later, when the swelling of the face had disappeared, as also did all his other unpleasant symptoms. I now left him, ordering tincture iron gtt. xv every four hours, alternating with turpentine emulsion—the latter for the fever symptoms, for its diuretic effect, and as a general diffusive stimulant. I left him this time confident that about twenty-four or forty-eight hours, at the outside, was his probationary period for this life.

I saw Mr. H. (on whose farm the patient lived), three days after my last visit, and was informed that the man was in fine spirits, had a good appetite, and was improving rapidly. I sent syrup of hypophosphites, to be taken in conjunction with the other treatment, and directed that the aperture be kept open, and a free drainage induced. He was left to nurses of his own race and color, who neglected this important part of the treatment. The wound closed, the drainage stopped, and the patient died two days afterwards.

This is the fourth case of abscess of the liver that the writer has operated upon, and the only one of the four that died, though one of the other cases was a very delicate and nervous woman about 45 years of age, which had sanitary and dietetic surroundings. The results of the operations in this case suggests the following conclusions:

1. Always operate if a reasonable diagnosis is made out.



2. Anæsthetics are not necessary in every case for this operation.

3. A free incision and a rational treatment warrant a more flattering prognosis, and a larger percentage of recoveries than our standard authorities lay down.—*Four. Amer. Med. Ass'n.*

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### ELECTRICITY IN GYNÆCOLOGY.

Dr. Paul F. Munde read an exceedingly able and practical paper before the New York Academy of Medicine on the subject "Electricity as a Therapeutic Agent in Gynæcology." He enumerated the following cardinal points which are useful to remember in making applications in other diseases as well as in special diseases of women:

1. The galvanic current is far more generally useful than the faradic, which, as a rule, has a stimulating effect. The galvanic, on the other hand, acts as a sedative.

2. A mild, steady galvanic current will answer every purpose, and is in every way preferable to a powerful, interrupted one. The faradic current, however, is useful in proportion to its strength.

3. Whenever the constant current causes pain, it is doing harm.

4. Personally, he could never decide which pole, the negative or the positive, should be placed within the body, provided care was taken that the current should not be too strong. The effect is apparently the same, whichever pole is used internally. There is, however, one prominent exception. In cases where there is circumscribed pain, the positive pole is the one to be placed near the painful point. In using the faradic current, it is of no consequence which pole is employed internally or externally.

5. He had always found it safe to begin with a mild current and gradually increase it to the required strength.

6. When internal electrolyzation is to be employed, it is always best to introduce the internal pole before closing the connection, on account of the sensitiveness of the external parts. Dr. Munde said he employed an electrode covered with leather for introduction into the vagina, but that he had been recently informed by an electrologist that this in reality afforded no protection to the parts.

7. To be of any service, the treatment must be frequently repeated, for a considerable length of time. As a rule, it is useless to make applications less frequently than twice a week, and in many cases they should be made every other day. A course of treatment by localized galvanization should last from three to six months.

8. The results of faradization in chronic affections are less favorable than those of galvanism. But, while relief from pain and an amelioration of the general condition are very often obtained by this means, a complete cure is not to be looked for in many of the affections which come under the gynecologist's notice.

Among the pathological conditions referred to in which treatment by electricity is applicable, were deficient development of the uterus and ovaries, amenorrhœa, subinvolution and menorrhagia, where there is deficient development faradization should be employed in conjunction with the use of sponge tests and constitutional measures. For the treatment of chronic pelvic cellulitis, of obstructive and neuralgic dysmenorrhœa, the galvanic current often benefits after all other forms of treatment have failed.—*N. W. Lancet.*

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### ACUTE ARTICULAR RHEUMATISM?—AN UNIQUE CASE.

Dr. F. Hibbard presents the following in the November number of the Cincinnati *Lancet and Clinic*:

I was hurriedly summoned, a few days since, to see a child which the father said was paralyzed.

An examination of the patient, a robust, hearty child of only five months age, revealed the lower extremities flexed and held in a stiffened position: the arms flexed with the fingers straight and dropping from the metacarpo phalangeal articulation. The history brought out the fact that the child had played in a basin of water, splashing itself until wet and remaining sometime before the clothes were changed. On the day before, the mother stated that the child had been restless the after part of the night.

I found, upon tickling the bottom of its feet and palm of hands, that it would immediately draw up its limb, but would cry out as with pain. Any movement of the limbs would produce the most violent fit of crying. There was no swelling of the joints, only a slight redness of the skin, most perceptible at the ankle joints. The temperature was 104.

I hastily informed the family that it was not paralysis, certainly not of the vocal organs.

I advised hot applications to the joints and left an emulsion of gum acaciæ and glycerine with five grains of salicylic acid to the teaspoonful, and directed a teaspoonful to be given every three hours, until better. As it was some distance in the country, I did not see the child until the next day: found it playing, and

by the day after the soreness had entirely disappeared, and the child remained well.

It is needless to state, that it being my first experience with such a case, I was nonplussed and only arrived at the diagnosis of acute articular rheumatism by careful exclusion. Smith states that acute rheumatism does occur in children. Bartholow teaches that it rarely, if ever, occurs before the age of seven.

My conversation with old practitioners leads me to suppose it a very rare complication and to reporting the case thus fully.

### INFLUENCE OF MARRIAGE ON CHOLERA.

A recent number of the *Journal des Assurances* contains a short article on the mortality from cholera to which married and single men in Paris were respectively subjected during the last visitation of that disease in the autumn of 1884; and as the matter is worthy of some attention, we append a free translation of it:

"The statistical returns of the city of Paris give an analysis of the deaths occasioned by the last cholera. We extract the following points for consideration which it may be interesting to notice. It is known that old men are especially liable to cholera, also persons who have been brought to a low state of health by grief, fatigue, privation, or excess: but, besides these, the civil condition of men exercises a considerable influence on their susceptibility to the malady. The following figures will enable our readers to judge of this:

#### DEATHS OF MALES OUT OF 100,000 POPULATION IN PARIS FROM NOVEMBER 3 TO 20, 1884.

AGE.	SINGLE.	MARRIED.
25-30 .....	51 .....	18
30-35 .....	78 .....	21
35-40 .....	58 .....	40
40-45 .....	152 .....	44
45-50 .....	83 .....	47
50-55 .....	167 .....	37
55-60 .....	83 .....	57
60-65 .....	117 )	46
65-70 .....	89 )	
70-75 .....	455 )	

"This table shows clearly that at all periods of life single men presented about two or three times more deaths than married men. The social position of many bachelors, and especially their habits of living (for a great number of them would be obliged to live in unhealthy proximity to one another) may per-

haps explain this surprising difference, which, indeed, deserves a deeper study than which it is possible to make from the facts supplied by the *Bulletin de Statistique*. Another fact which is no less remarkable is that cholera has attacked men and women most unequally. From the 3d to the 20th November there were 561 deaths of males (or 50 out of 100,000) and only 379 deaths of females (or 33 out of 100,000)."

The foregoing statistics are not uninformative, although they are put forth in a loose, inexact way that goes far to rob them of any value they might have. The proportions of male and female deaths, referred to in the closing sentence of the extract, evidently relate in each case to 100,000 persons (males and females combined), although this is not so stated, and in the absence of remark it might well be thought that the male deaths were compared with 100,000 male inhabitants of the city, and the female deaths with an equal number of the female units of the population. On the main question of the respective susceptibility to cholera of married and single men, it is impossible to form any opinion until the relative numbers of married and single men in the total population are known. The death-rate prevailing among any special class of lives can only be determined by taking the ratio of the observed deaths in that class to the total number of such persons who were exposed to the risk of death. Hence, if we accept the figures given by the official *Bulletin* as correct and unimpeachable, we are yet quite unable to compare the mortality from cholera among married with that among single men until we are informed how many married and single men respectively were in Paris at the time of the outbreak. The *Journal des Assurances* devotes much of its space to statistical questions, and its knowledge of insurance matters seems wide and sound. We are surprised, therefore, that it should have shown itself ignorant of so fundamental a principle as that to which we have made reference.—*London Insurance Record*.—*The Sanitarian*.

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## HOW TO LEARN AND HOW TO REMEMBER ANATOMY.

In a very instructive lecture on the above subject by Dr. E. Souchon, in the *New Orleans Medical and Surgical Journal* for December, we find the following useful guide to describe an organ:

1. DEFINITION—Synonymy, Etymology, History.
2. DIVISION OF THE ORGAN into separate portions.



3. NUMBER. Single or Double—Supernumerary organs. Absence of the organ.
4. DIMENSIONS—1st. *Relative Size*, or size compared to other organs or to familiar objections. 2d. *Absolute Size*: Diameters; transverse, vertical, antero-posterior. Calibre.
5. SITUATION—1st. *General Situation* or region it occupies. 2d. *Relative Situation* or compared to the surrounding organs.
6. DIRECTION—1st. Compared with *axis of the body*. 2d. Compared with *its own axis*.
7. MEANS OF FIXITY—Vascular Connections.—Adhesions.—Ligaments.—Supported by other organs.
8. IMMOBILITY of the whole organ—of a part of it—*Intrinsic* immobility. *Extrinsic* Immobility or Communicated by other organs—Extent of Immobility, Exceptional Immobility.
9. SHAPE—1st. Compared to a geometrical figure. 2d. Compared to the shape of a familiarly known object.
10. SURFACES:

—Synonymy:

—Direction: forwards or backwards.—Above or below.—Intermediate direction.

—Shape: Plane, Concave or Convex in the vertical or transverse direction.

—Peculiarities: Projections (folds, processes, ridges or crests, tubercles, protuberances). Depressions, orifices (size, shape, boundaries, structure, contents), blind foramina—grooves and canals (depth, extent, contents, vessels or nerves or organs).

When enumerating peculiarities, begin on the median line and then on the sides; proceed from before backwards or from within outwards; or from above downwards.

—Relations: With skin (*i. e.* to what part of the surface it corresponds) or with bones, joints, muscles, viscera, vessels and nerves.

#### 11. BORDERS:

—Synonymy.

—Dimensions.

—Direction: 1st. *Relative Direction*, vertical, horizontal oblique, forwards or backwards—or above or below—or inwards or outwards. 2d. *Absolute* direction: straight, sinuous, concave, convex.

—Shape: Blunt or Sharp, or Bevelled at the expense of one surface or the other.

—Peculiarities, { as for surfaces.

—Relations,

All Thick Borders ought to be subdivided into *two edges* or

lips and an *interstice*. Give for each: peculiarities, insertions and relations.

12. ANGLES OR EXTREMITIES: same as borders.

Base and apex: same also.

13. STRUCTURE:

—Color.

—Consistency: Density, Friability, Elasticity, Retractivity.

—Envelopes or Coats: Thickness, Resistance, Elasticity.

External Surface (relations, adhesions). Internal Surface (relations, adhesions, processes from internal surface).

Reflection into the interior of the organ.

—Stroma: Is delicate or apparent; is composed of connective tissue, or elastic, smooth muscular fibres.

—Proper or characteristic Elements: Cells, Tubes, Fibres, Prisms.

—Capillary Arteries: Veins, Lymphatics, Nerves.

—Excretory Duct of Glands (as a separate organ).

—Lining Membrane of a Hollow Organ: Thickness, Consistency, Elasticity, Adhesive Surface, (degree of adhesion): Free Surface: color, peculiarities, epithelium, glands.

14. CHEMICAL COMPOSITION: Organic, Inorganic Elements.

15. DEVELOPMENT OF THE AGES.

16. PECULIARITIES OF VARIETIES, or anomalies due to Sex, Habits, Trades, Constitutions, Individualities, Nationalities, Races.

## CORROSIVE SUBLIMATE AS A SURGICAL DRESSING.

While we are all familiar with the fact that the bichloride of mercury is a most valuable disinfectant, yet we doubt whether its full power is realized and whether it holds that high place in the estimation of surgeons to which its undoubted efficacy entitles it.

Considering it as one of the most valuable aids to the surgeon, we deem that all should be familiar with its merits, and we therefore desire to call notice in an especial manner to its use. In one of our hospitals in this city, solutions, varying from 1 to 1000 to 1 to 5000, are kept constantly on hand, and when cases of bruised and lacerated limbs are brought in they are at once enveloped in these solutions and the results are truly remarkable. One case is so striking as to merit special note.

A small child was brought in with his leg so mangled (bones comminuted, etc.,) that the whole surgical staff (three prominent

surgeons) decided that amputation was imperative. To this the parents so strongly objected that the surgeons were forced to yield. Explaining to the parents the almost certainty that the child would die, and placing the responsibility where it rightly belonged, the limb was encased in bichloride sawdust. Presto, result! an absolutely perfect limb.

Many such cases could be cited, but suffice it to say that by the use of corrosive sublimate we can save many limbs that would otherwise be sacrificed.

In this connection it will be well to note that Dr. R. J. Levis has great faith in the potassio-mercuric iodide. He has tablets prepared of such strength that one dissolved in a pint of water gives him a  $\frac{1}{12000}$  solution, which with hydro-naphthol constitute his antiseptic armamentarium.—*Medical and Surgical Reporter*.

## PREVENTION OF BAD TEETH.

A foreign exchange says the troubles which arise from disease of the teeth, or from their loss, are not always directly referable to their cause. When actual toothache is present there is of course little doubt, and the remedy of extraction at once presents itself. At the same time it must be remembered that the forceps does not undo the work of disease or make amends for its ravages. A jaw which has lost the best part of its function with its teeth, or which bites unequally with the scattered survivors of its former armament, is but a deceitful guardian of the passage to the stomach; while it seems to do duty in mastication, it passes intact much that is unfit for the immediate action of the gastric juice. Were the relationship between bad teeth and dyspepsia, with its consequent discomforts, better understood, we should probably hear less of the prevalence of dental caries. Greater attention would then be paid to the small organs whose obscure influence on the general health so fully justifies their preservation. Specific constitutional disease, drugs, and other special factors no doubt account for a certain amount of dental decay. Neglect, however, accounts for much more. Want of care in choosing food, and particularly in cleansing the teeth, has nearly everything to do with the dental worries of a great many people. A point well worthy of note in this connection is that most of the permanent set of teeth come into active operation during childhood or early youth. It is hardly to be expected that children, if let alone, will pay much attention to the state of their mouths, unless driven to notice an aching stump. Thus it happens that most children have lost one or several teeth before they are well into their teens. Here, then, there is need for pa-

rental supervision. Mr. W. M. Fisher, of Dundee, has been led by certain observations, which proved the defective condition of the teeth in a majority of school children, to suggest that some regular system of supervision by a dentist be adopted as a part of school management. The expenses he would have defrayed by the parents, or, should they be too poor, by the State, out of the education grant. This plan has actually been adopted in the parochial school at Anerley, in Surrey. We have long been of opinion that it would be most desirable if the health of children in all schools could by some plan be periodically passed under review by a medical inspector. The possible obstacle to such an arrangement would be the expense. This may not prove insuperable, and if it do not, we may hope that this method, and also some plan of dental supervision, may find their place among the recognized forms of school discipline.—*Medical and Surgical Reporter*.

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### LITHIASIS.

It is generally understood that physicians, when sick, are slow to take medicine, either of their own prescribing, or on the prescription of a brother practitioner: and in many cases, even when not dangerously sick, they are poor prescribers for themselves. The following case illustrates this, and at the same time contains a *practical lesson*. A physician in regular practice, was sick with backache and headache, with some fever, with slight evening exacerbation, which would go off with a sweat at night. He had also some tenderness of liver and stomach, urine very high colored. Giddiness or swimming in the head was also a prominent symptom, and had been, even before he took down.

A dose or two of calomel, with morphine at night, gave some relief, but the tenderness over the liver and stomach became much worse. In this condition a brother practitioner visited him. Though sick, he was able to talk, and in the course of the day, the conversation turned on Lithiasis, and he (the sick one) took occasion to make a few plain remarks on the diagnosis and treatment of this condition, citing several cases in practice, and laying special stress on the value of colchicum and alkalies in the treatment of such cases, and referring many symptoms of derangement of various organs, such as indigestion, palpitation, pruritus, eczema, et id omne genus to this peculiar condition of system. He threw such light upon the subject in general, and upon his own case in particular, that though he never once thought of that being his trouble then, (notwithstanding he had treated himself several times through the summer for that particular condi-



tion and with marked relief,) the visiting brother saw enough to cause him to ask, "Don't you think that treatment would suit your case?" He quickly assented. And it struck him as the clearest thing he had ever seen, and before night, without further consultation, he took two or three doses of wine of colchicum and bicarb. potassium, and by next day, with the help of a little cream of tartar, his bowels were moved very actively and often, and in twenty-four hours he was up, ready for light duty, the soreness of the liver and stomach having gone, as if by magic. And during all his sickness of about a week he never thought of this, his old complaint, till it was suggested by a brother.

I would not be understood to say that eczema is always or even generally of a gouty nature, but it frequently is, and there is one form that is almost pathognomonic of the gouty diathesis. I refer to *eczema of the ears*, in plethoric, ruddy adults; and congestion, redness and burning of the ears, *not amounting* to inflammation, is often the precursor of an attack of gout somewhere; and when present, it is an index of the peculiar diathesis, and will afford a key to the situation in many cases, the nature of which, would be otherwise doubtful.

And when we remember that congestion or inflammation of a purely gouty nature, is liable to attack any of the internal organs, as the stomach, or liver or lungs, etc., which will yield readily to treatment addressed to the gouty condition of the system, we see the importance of recognizing at a glance, these surface indications of such condition as furnishing a key to the proper therapeutic measures. For whatever treatment may be demanded to meet certain symptoms, such as pain, cough, restlessness, vomiting, etc., etc., it is all-important in order to a speedy cure, where such condition of system exists, that it be treated with colchicum and alkalies, especially the salts of potassium and lithium.—*Southern Practitioner*.

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## BILIARY CALCULI.

The following is an abstract of the histories of three cases of biliary calculi, with remarks, that were read before the New Orleans Medical and Surgical Association:

Mrs. B., age 34 years, a seamstress, widow, and the mother of ten children, began complaining of pain in the right side, the top of the head and the eyes. For four years she was subject to every imaginable form of treatment, but with no relief. Finally, she began to suffer every seven days with a chill, followed by fever and pain in the right hypochondrium. Still the diagnosis

was not correctly made until one evening she was suddenly taken with every symptom of an attack of hepatic colic, which was fully established by further observation.

The second case was that of an Irish washerwoman, sixty years of age. Her attacks, which were frequent and severe, were ushered in by a chill followed by high fever, and were attended by a choking sensation and pain over the region of the heart. Finally, a consulting physician during a particularly violent attack made a diagnosis of gall stones, which was later verified by the finding of the calculi.

The third case was a policeman, thirty-two years of age. He gave a history of headaches, dull pain over the liver, lack of relish for meats, especially fat meat, constipation, and occasional shooting pains through and over the entire abdomen. A diagnosis of biliary calculi was made, and under the use of olive oil abundant stones were passed.

The pathology, the supposed causes, and the diagnosis of biliary calculi were passed in review. While stating the several symptoms which are commonly relied upon for a diagnosis, special stress was laid upon the aversion to fats on the part of sufferers from the affection. This symptom was marked in all of the above cases. The only author that alludes to this symptom is Trousseau, and he does so only slightly.

In the matter of treatment, morphine was recommended to ease pain. Large doses should be administered; nothing less than one-half grain hypodermatically, and repeated in fifteen minutes if necessary. Atropia, in the fashionable combination of atropia,  $\frac{1}{120}$  grain and morphia  $\frac{1}{8}$  grain, was especially discounted, on the grounds of being unscientific and preventing frequent administration of the opiate. After pain is relieved olive oil in pint doses should be used to expel stones. The use of chloroform, ether, turpentine, phosphate soda, etc., are in the opinion of the writer utterly useless. To prevent a recurrence of the stones, the waters of Carlsbad and Vichy are of much service; to the same end a vegetable diet and open air exercise are recommended.—*T. S. Darney, M. D., in N. O. Med. and Surg. Jour.*

## EUCALYPTUS IN TYPHOID AND OTHER FEVERS.

Dr. Leighton Kesteven, contributes his observations in this subject to May number of *The (London) Practitioner*:

While treating cases of typhoid fever in the Brisbane General Hospital, the idea occurred to him that the oil of eucalyptus would be efficacious. In the next eighteen months he treated

220 cases of the fever with it, with only four deaths, and these four cases would probably have died from other causes than the fever. His dose is now about ten minims every ten hours. It does not agree well with all stomachs when given simply with mucilage: but trouble in this respect can be entirely overcome by first carefully emulsifying the ten drops of oil with mucilage, and then the addition of a half drachm each of aromatic spirits of ammonia, spirits of chloroform and glycerine—the latter entirely removing the rough semi-resinous taste of the oil.

This medicine acts, *first*, by steadily and permanently reducing the force and frequency of the pulse,—indeed acting with marvellous rapidity in some cases: *secondly*, by lowering the temperature, which occurs less rapidly and may be secondary to, and dependent on the lowering of the pulse: *thirdly*, by the beneficial effect on the tongue—almost immediately alleviating the distressing dryness so universal in typhoid fever, and removing the thick brown coating, leaving, relatively, but little fur, frequently cleansing the tongue entirely in a very short while: and, *fourthly*, the skin becomes moist and soft, giving comfort to the patient.

The Doctor also pins great faith to the liberal use of whisky from the beginning of attack—even as much as thirty ounces in the twenty-four hours. Ordinarily, he feeds on milk thickened with isinglass, beaten up eggs, milk and soda, cocoa, and—where diarrhoea exists—ground rice and milk. In asthenic cases ounce doses of chicken broth (concentrated to ten ounces from a whole fowl) every half hour or longer, the juice of half cooked mutton, or beef tea made in a pot without water strained through a fine muslin should be used. For the abdominal tenderness, apply ice-cold compresses, and allow ice to suck. Apply ice to the shaved head for cephalagia, and use frequent cold “packs” from head to knees if temperature rises. Change the bed linen night and morning without letting the patient get out of a horizontal position.

The Doctor thinks probably the eucalyptus acts as a germicide. In most cases, the fever is entirely over in ten or twelve days, although he keeps his patients in bed the traditional three weeks.

Experimentally, he has used eucalyptus oil in two or three cases of pneumonia, with the most marked benefit.—*Canada Lancet*.

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## SUBCUTANEOUS INJECTION OF THE SALTS OF QUININE.

The occasional necessity for the injection of quinine subcutaneously, not only in severe malarial affections, but also for anti-

pyretic purposes, must have compelled many physicians to reflect on the best methods of avoiding the disagreeable consequences which too often follow such a use of most of the salts of that drug.

It is generally in violent and pernicious malarial complaints, in which both the stomach and rectum are so irritable that medicines are not retained long enough to permit of its satisfactory absorption into the system; or where, without such irritability there is some mechanical obstacle to the administration of food and medicine by the mouth, and we wish to reserve the rectum for the purpose of nourishing the patient; and occasionally, too, in a few cases of hyperpyrexia, in which the danger from excess of heat is imminent, while other methods of reducing the temperature are contra-indicated, and every minute is of value, that the resort must be made to the hypodermic injection of such powerful antipyretics as quinine, in quantities likely to produce a rapid fall of temperature. There are probably great differences of opinion as to the doses required under such circumstances, but I have thought it necessary, more than once, to put as many as thirty grains of quinine under the skin in a few hours' time. As it is scarcely possible to inject more than five grains at any one point—smaller doses indeed, such as two or three grains, being distinctly preferable—the number of injections and the pain produced, are matters of no small importance. The method I have latterly adopted has given decidedly better results than any previously tried, and can be stated in a few words. The two best salts of quinine to use are the bisulphate and the hydrochlorate. Both are fairly soluble without acids, but the bisulphate has the advantage of being considerably cheaper. One grain of that salt will dissolve readily in six minims of equal parts of the purest glycerine and of distilled water at the temperature of the body, and when thrown at that temperature into the looser subcutaneous cellular tissue—the only part into which quinine should be injected—will be rapidly absorbed without deposition of any crystals of the drug. To this solution two per cent. of pure carbolic acid must be added. Thirty minims of such a solution, containing five grains of the bisulphate, may then be used for one injection from a syringe of double the average capacity—now, as a rule, just, about fifteen minims; and although it is probably better, as previously mentioned, to inject less at one point, no local or general injurious effects have followed the numerous applications of the maximum quantity stated, which have been made since I have been in the habit of adding the carbolic acid to the diluted glycerine solution of the quinine. The local anesthetic action of the carbolic acid, too, is unquestionably of great value in diminishing the pain attending the hypodermic use of such an irritating medicine as quinine.—*British Med. Jour.*



## THE TREATMENT OF NIGHT SWEATS.

I send herewith a prescription for night sweats, which I have used for many years and found to be very efficient. It is very rare that more than three pills in the twenty-four hours are necessary to promptly stop the trouble; and, notwithstanding the fact that these pills are directed only for the relief of a disagreeable symptom, many patients suffering from phthisis declare that they are of real benefit in aiding a case of the disease, and continue to persist in their long use after night sweats have ceased.

This prescription I have found very efficient, also, in relieving the nervous prostration that is so often seen in those who drink alcoholic liquors to excess:

R. Oxide of zinc,	12 grains.	
Pyrogallic acid,	24 grains.	
Sulphate of atropia,	1-24 grain.	
Extract of lupulin,	48 grains.	M.

Make 24 pills and silver coat.—Dose, one pill three times a day, soon after meals.—*Dr. Smith, in Gaillard's Medical Journal.*

## INIQUITOUS DECISIONS.

The legal and medical professions are generally on very good terms with each other, in this country at least. But there are at times some most extraordinary and unjust decisions sent down from the bench upon us. One of the most glaring instances of this was the case of Dr. Bradley, in whose behalf the medical profession of England has shown so much sympathy and generous help.

Now we hear of a case in California quite as iniquitous, judging from the facts given in the *Pacific Medical and Surgical Journal*.

In April, 1884, Dr. Graves, of Petaluma, Cal., was called to see Mrs. Winters, the wife of a laborer whose family he had attended gratuitously for nearly sixteen years. He found that the woman, who was fifty-eight years of age, had fallen from a height and injured her ankle. The limb was very much swollen, so as to interfere with examination, but no crepitus could be elicited, neither was there any displacement or shortening; and, as the swelling continued, the limb was placed in position and wrapped loosely in cloths saturated with anodyne lotions. The patient, we are told, received every attention from Dr. Graves, but there was left some stiffening of the joint and a very slight inversion of the foot. No complaints were made until a new doctor arrived in the town, who told the patient that the limb had been badly

treated, and advised her to sue for malpractice. "The case," continues the *Journal*, "was examined by ten of the chief surgeons of the State, including Drs. Lane, McLean, Morse, and Dennis, all of whom said that there might have been a sprain or an incomplete fracture of the external malleolus, but that the ends of the bone were in perfect apposition and never had been separated, and that the stiffening was probably due to inflammatory adhesions.

"Two other doctors, one of them being he who had advised the suit, testified that there was shortening of the limb, and that the lower fragment of the tibia had been driven up and behind the fibula. One of these would-be surgeons, Dr. Wells, is nearly eighty years of age, and had not read a work upon surgery for nearly thirty years; the other, Dr. Ivancovich, confessed that he had no special experience in surgery. Their incompetence may be judged from the way they measured the patient's limb *in court*. This was done by taking a carpenter's rigid rectangular rule, and measuring the limb as she maintained the upright position.

"The result was that in the opinion of nine jurymen the testimony of two unknown, inexperienced general practitioners outweighed that of ten specialists in surgery, all of whom are well known throughout the State, and some of whom possess a national reputation, so that a verdict was returned in favor of the plaintiff, awarding her \$8,000 damages."

It appears to us, from the facts given, that this decision is so gross an outrage upon the profession, as well as so great a personal injustice and misfortune to Dr. Graves, that the physicians of California are in duty bound to help straighten out the matter. They should either get the decision reversed, or contribute to the needs of Dr. Graves.—*The Medical Record*.

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## NEURASTHENIA.

By this term we mean the condition of *nervous exhaustion*.

It may be manifested in a variety of ways. Its symptoms will depend upon the type which exists—cerebral exhaustion or spinal exhaustion—and also upon special idiosyncracies peculiar to the patient. No two cases exhibit identical manifestations of nervous depression. Some patients who are suffering from cerebral neurasthenia manifest its effects in the voice, others in mental disturbances. The heart's action may be alone disturbed in some cases, the stomach may give out in others; some may complain alone of muscular troubles; some may notice its effects

in the eyes: some are rendered sleepless: a few complain alone of skin disturbances, and so on throughout the different parts of the entire human organism.

You can understand how these apparently discordant facts may be reconciled when you consider the fact that, by means of the brain and spinal marrow and the nerves which unite these centres to the different parts of the body, we are enabled to see, hear, taste, smell, appreciate, touch, swallow, breathe, and perform voluntary muscular acts.

It is by means of our nerves alone that the heart beats: the digestive processes go on, without our knowledge or control, through the same agencies: the blood-vessels contract and dilate in accordance with the demand for blood telegraphed to the nerve-centre by the different organs and tissues: and every process pertaining to life is thus automatically regulated. Now it is easy to see how a debility of so complicated an electric mechanism as the nerve-fibres and the nerve-cells of a living animal are, can upset all or any one of the individual functions enumerated. Many of our houses are furnished to-day with electric bells, by means of wires distributed in the walls. In some houses we light the gas-jets, and even the rooms themselves by means of the same subtle fluid. When the battery becomes weak, or when the wires are disarranged or broken, what may be the result? Some of the bells may cease to ring when the button is touched, while others work properly. Perhaps the electric light may fail in some rooms and burn with its accustomed brilliancy in others. The gas-jets may not be properly ignited. So it is with the nervous apparatus of man. From the same cause, one patient may have nervous dyspepsia, another sleeplessness, a third sexual debility, a fourth weakness of the eye-muscles, a fifth disturbances of the skin.—*New York Medical Journal*.

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## PTOMAINES: THEIR ORIGIN, CHARACTERS, AND REACTION.

Profs. Anrep and Poehl (*London Medical Record*) sum up their investigations and the literature on this subject thus:

1. Putrefaction, fermentation, and other yet indefinible alterations of albuminous substances, are accompanied by the generation of alkaloid-like bodies, termed ptomaines.
2. The number of ptomaines is very great, and their chemical and poisonous properties are very different.
3. There are known fixed, and volatile, fluid and solid, amorphous and crystalline ptomaines. All fluid ptomaines do not contain oxygen.

4. Almost all ptomaines change red litmus to blue, and syrup of violets to green.

5. Like all alkaloids they form salts with acids, the formation proceeding without giving off water.

6. In regard to their solubility, ptomaines behave very differently: some of these are soluble in water, others in ether, alcohol, benzine, chloroform, and amyl-alcohol. Ptomaine salts are easily soluble in water.

7. Some ptomaines are tasteless and colorless; others again possess an intense bitter taste, or aromatic sweetish odor; others again evolve a cadaveric odor, or one resembling coniine or nicotine. When treated with acids they sometimes emit a pleasant floral odor.

8. Ptomaines obtained from rye meal which has been subjected to fermentation, give the same reaction as the ptomaines of any other extractions. These reactions are as follows:

(a) A solution of iodide of potassium with biniodide of mercury produces a whitish precipitate in a ptomaine solution slightly acidulated with hydrochloric acid. Twenty-four hours later, microscopic examination detects that the precipitate consists of minute prismatic crystals.

(b) A solution of iodide of potassium with iodide being added to an acidulated ptomaine solution, produces either a flocculent or a finely granular red-brown precipitate, which is insoluble in diluted hydrochloric acid.

(c) A solution of phospho-molybdate of sodium gives a yellowish amorphous precipitate which is insoluble in diluted nitric acid, but on the addition of liquor ammoniæ in excess, at first takes a blue-green color, and afterwards dissolves, giving either a bright blue or green solution. The blue color is mostly observed during the first stages of the putrid decomposition. The original precipitate produced by phospho-molybdate of sodium on being heated assumes a green color without any of ammonia.

(d) Phospho-tungstic acid gives whitish or greenish precipitates which are insoluble in dilute sulphuric and hydrochloric acids, but easily soluble in ammonia.

(e) A solution of tannic acid gives a white precipitate; and the latter does not appear if tartaric acid be present.

(f) A solution of iodide of potassium with iodide of bismuth in presence of diluted sulphuric acid, gives a yellowish precipitate, part of which passes into solution on heating, and reappears again on cooling.

(g) A solution of iodide of potassium with iodide of cadmium sometimes produces precipitates which are so luble in th excess of the reagent, and which by degrees assume a crystalline structure. This reagent precipitates the products of the



stages of putrefaction, which are not precipitated by iodides of potassium and cadmium.

(*h*) In some cases a solution of corrosive sublimate gives precipitates which gradually take a crystalline structure: in other cases ptomaines are indifferent to this reagent.

(*i*) A solution of chloride of potassium gives, with some of the ptomaines, precipitates which are usually crystalline and soluble in hydrochloric acid and consist of a double salt.

9. Ptomaines are optically inactive bodies.

10. The color reactions of ptomaines are as various as those of the vegetable alkaloids.—*Detroit Lancet*.

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## DIAGNOSTIC VALUE OF THE WHITE STREAK IN SCARLATINA.

This phenomenon, which can be produced by rubbing a soft body upon the skin which is affected with the scarlatinal eruption, is considered by the author an important diagnostic sign of scarlatina which has hitherto been overlooked. When in the normal condition one draws a line upon the skin with a smooth surface, as the rounded extremity of a pencil, and uses moderate pressure, there may be observed at the points touched a white line which lasts for some time. This paleness is due to the moderate excitation of the vasomotor nerves and the contraction of the small vessels which follows it. If the pressure has been very strong, in place of a white line a red line bordered by two white ones is produced. The excitation in this case has paralyzed, temporarily, the small vessels in place of contracting them, while in the area which is contiguous where the pressure has been less strong the excitation has led only to constriction of the vessels. In certain diseases the effects which are obtained by this procedure vary greatly. Trousseau, for example, has shown that in patients suffering from meningitis a red line is produced by pressure with the greatest ease, and this has been called the meningitic line. It may also be produced in all the diseases which lead to perturbation of function in the nervous system. Thus, it may be produced in many cases of typhoid fever, in erysipelas, variola, rubeola, and the diphtheritic eruptions. But it is not the same in appearance in scarlatina during the entire period of the eruption. In place of getting the red meningitic line, a pale, rather persistent line is produced, which extends plainly to the bottom of the eruption. This fact was long ago noticed by Bouchut, and was considered a valuable sign as a means of diagnosis, both in children and adults. It is not equally prominent and distinct at all periods of the eruption, Velpeau having observed

that it is not produced when the efflorescence of scarlatina is at its highest degree of development. In the diphtheritic eruption, which resembles that of scarlatina accompanied with angina, the excitation of the skin produces a red line and not the white one of scarlatina. This sign is especially valuable in those cases of measles in which the eruption closely resembles that of scarlatina. The same is true in variola, in which other differential signs are often absent. It must be borne in mind that the important feature in making this test is that the white line appears upon the surface which is covered by the eruption.—*Archives of Pediatrics*.

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### CAPSICUM IN HÆMORRHOIDS.

A case is mentioned by a correspondent of a Peruvian medical journal of a case of bleeding piles cured by capsicum. The patient was a man of 28 years of age. He was much distressed by passing variable quantities of blood after going to stool, and suffered a great deal from anal irritation and tenesmus. No tumor could be detected. He had formerly been in the constant and daily habit of using a violent purgative for ten months, and after he left it off, obstinate constipation followed, and it was under these circumstances that the hæmorrhage commenced. The writer tried all kinds of remedies and regulated the diet without producing any great improvement, and at last was contemplating surgical measures when he happened to mention the case to a hospital physician, who suggested a trial of capsicum, as he had himself been cured of a very obstinate form of chronic dysentery by its means, and he felt sure that it possessed the property of acting on the rectum. This was consequently prescribed with meals, and the doses gradually increased. A marked improvement soon was observed, and at the end of a couple of months a complete cure was effected.—*Maryland Med. Journal*.

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### A LITTLE LEARNING IS A DANGEROUS THING.

The smart young lady who wrote a note to the doctor, asking him to visit her brother and bring his urethra with him, has been discounted by a well-informed medical student of Indianapolis, who was asked recently by his sweetheart to examine her throat for some slight ailment. Being anxious to exhibit his embryonic medical talents to his fair innamorata, he called for a spoon, dexterously depressed her tongue, gazed knowingly into the yawning chasm thus brought into view, and then, with a look of profound wisdom, informed her that *her vulva was greatly elongated*.—*Ind. Med. Journal*.

### A PROMINENT PRACTITIONER SUED.

Dr. A. E. M. Purdy, a prominent practitioner in New York City has recently been sued, and a judgment for five hundred dollars obtained by a patient whom he caused to be sent to the eruptive hospital, suffering from what the doctor diagnosed smallpox. The patient was sick only a short time, and on being discharged sued the physician for ten thousand dollars, claiming that the diagnosis was incorrect and that the disease was simply a dermatitis due to a preparation containing acetic acid coming in contact with the face.

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### THE TREATMENT OF NIGHT-SWEATS.

Good results have been obtained in the treatment of the night-sweats of non-phthysical patients in the following manner: Two drachms of chloral are dissolved in two tumblersful of a mixture of equal parts of brandy and water. The patient is bathed each evening with this solution, or night clothing saturated with a solution and then dried is worn.

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### THE KLEPTO-COCCUS.

We learn with pleasure that Professor Meandra has succeeded in isolating the bacillus of kleptomania. It has long been thought that this disease owed its origin to an organism of a snaky, elusive nature, which rendered detection difficult, but it remained for Professor Meandra to first demonstrate its existence. The difficulty was, of course, to obtain pure cultivations. At length Professor Meandra secured a magpie of well-known thievish propensities, and removing a small portion of its brain, under the spray, he began the first of his long series of experiments. The organism can be readily grown in beet-juice (prepared by beating beets and straining) or in cabbage infusion. It stains easily of a deep steel color. Under a power of eighty diameters this organism presents a hook shape, thus  $\hookrightarrow$ , which gives it the name of Meandra's Interrogative Micrococcus; we would, however, suggest (with due deference to the professor's taste) the name of hookey-coccus, both as more euphonious, and as applicable, no matter what position the organism may assume; it also indicates its character as well as shape. Injected subcutaneously into cats the effects of the hookey-coccus were remarkable. Several of these animals, let loose in a back-yard, were seen two days after to creep surreptitiously into some of the neighboring houses and kleptomize pieces of meat, fish, etc. While we cannot quote the whole of this important article, we

relate one interesting event. A quantity of beet-juice in which a cultivation was far advanced, was spilled on the floor of the laboratory. Three days after the professor missed his pocket-book, watch, and other articles of value; it was also noticed that several houses in the place had been visited and valuables taken. Mr. Lastees, the professor's assistant, a man of the highest respectability, was also missing. Professor Meandra thinks he must have inhaled some of the dry dust from the spilled cultivation. There was much excitement when the affair leaked out, and, as there are two banks in the town, the people petitioned the mayor to prevent all communication between the professor and the cashiers. There is no doubt that an attenuated cultivation can be obtained, in which case the criminals confined in the prison at Moros will be vaccinnated. We agree with this great investigator when he says, "the bacillus opens a wide field for thought—an almost unfathomable vista." "Many generations must pass," he continues, "before the last microbe is stained and mounted, drawn and photographed, and stamped with the name of its discoverer." "The next two hundred years will be known in history as the Microbian age."—*The Birmingham Medical Review*.

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### DIAGNOSIS OF PREGNANCY.

Well, now this unmarried girl comes to us because she thinks she is pregnant, and hopes we can do something "to put it away."

"What makes you think you are pregnant?" Dr. G. asks.

"Because I have placed myself in a position to become so, and have not seen my courses for two months," the girl replies.

As a rule, we cannot swear to pregnancy until we hear the foetal heart sounds; but there is strong presumptive evidence if the os is soft like one's lips. When the os is as hard as your nose, you may be reasonably sure that there is no pregnancy. Once in a long while a fibroid tumor will give us a soft os and cervix, but this is very exceptional. This condition we will find as early as the end of the first month, though it becomes more marked as pregnancy is further advanced. No matter what station in society a woman may occupy, no matter howsoever exalted her position, when we find a soft os and cervix, we have a right to suspect pregnancy. Here there is a little softening, but very little. Her abdomen is too fat to circumscribe the womb and discover whether it is enlarged, so that evidence is here lost.

There is only a shade of darkness about the nipple, not as much as there ought to be in pregnancy. This woman may not



be pregnant and may be suffering only from amenorrhœa. We will give her Blaud's pill—

Dried sulphate of iron.		
Carbonate of potassium,	aa	2 drs.
Glucose,		q. s.

M. ft. pil. No. xviii. S.—Two thrice daily for one week, and then increase one at each dose.

If she is not pregnant, this will bring on her menses, while if she is pregnant, it will not cause a miscarriage. Remember that a natural abortion is not very dangerous; it may be likened to a ripened apple dropping from the bough. For some reason the ovum has become detached from the womb, and it passes harmlessly away. But if you pluck a green apple, you will tear also the bough or break the stem from the fruit: so when you produce abortion, you tear the ovum from its firm adhesions to the uterus and cause lesions that may result in septicæmia—*Med. and Surg. Reporter*.

## THE CAUSES AND TREATMENT OF QUINSY.

F. P. Atkinson, M. D., writes as follows in the *London Practitioner*: Having been in years past a frequent sufferer from quinsy I have taken special interest in determining its cause or causes and the best methods of treatment, and I believe I can, after twenty years of experience, speak with confidence as to the correctness of my present views. First of all then I would say, it is essentially a disease of debility, and is more or less associated with *adolescence* and a strumous habit. The exciting causes are sexual excesses, bodily fatigue, irregularity of meals, long continued fasts, or in other words, excessive nervous or muscular exhaustion. Cold and rheumatism play little or no part in its production—nervous and muscular exhaustion, as I have said, are the immediate causes of quinsy, and both these make the person liable to take a chill and also rheumatic fever. However, I have rarely, if ever, in the whole course of my experience, seen these two co-existing in the same person. Again, it cannot be the result of cold acting directly on the throat, because laryngitis would then be a much more frequent accompaniment than it now is, and a second attack rarely follows till after the lapse of some months, no matter what the amount of exposure. The treatment I have to advise can scarcely be termed otherwise than a specific one, since I can with perfect truth affirm that very few, if any, of the cases have gone on to suppuration which have come to me at an early period.

The effervescing citrates will be found useful in allaying not

only this, but all other kinds of glandular inflammations, and I order twenty grains of bicarbonate of potassium to be taken with fifteen grains of citric acid every four hours in a state of effervescence. Guaiacum, which has long been known to be beneficial in throat cases, is best given in the form of lozengers made up with black-currant jam, in accordance with the directions of the pharmacopœia of the Throat Hospital, Golden Square. One of these lozengers should be sucked frequently. Iodine, when applied locally in cases of glandular inflammation, is known either to reduce the enlargement or to hasten suppuration, according to the stage in which it exists: and a gargle, containing from twenty to twenty-five minims of the tincture to the ounce of water, will be found particularly useful. This may be used by taking a little in the mouth, and shaking the head from side to side. Port-wine is an essential part of the treatment, and it is necessary for the patient to take from four to six ounces in the course of the day, besides plenty of beef tea and milk. By this method resolution is almost always brought about, and the patients are, with scarcely a single exception, able to resume their usual duties about the fourth day. The usual duration under the old methods of treatment was almost always from nine to ten days. I would particularly urge upon those who are willing to give the above mentioned method of treatment a trial not to be discouraged if the patient complain of feeling no better, or even worse for the first two days, but to persist with it all the same, and they will be certain to meet with the success they and their patients desire. Though the bowels are almost always confined it is not advisable to administer aperients, since as soon as recovery takes place they are moved as regularly as possible, without any extraneous assistance. When suppuration has commenced in the tonsils (which may be looked for about the sixth day, and made out by great throbbing in the ear on the effected side) it is best to omit the effervescing citrates and guaiacum lozengers, and depend upon the iodine gargle, together with the port wine and beef tea. Suppuration is by this means hastened and suffering curtailed. In conclusion I would ask those who put this method of treatment on trial, to keep a record of their cases, and after a time make a report both of the successful and unsuccessful ones, so that we may arrive at really truthful conclusions concerning this disease.—*Lancet and Clinic.*

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#### BETA NAPHTHOL IN THE TREATMENT OF SCABIES.

Josias has made a series of experiments on animals with naphthol to determine whether the case of Neisser's, where he-

moglobinuria supervened when a child affected with prurigo was treated with it was or was not exceptional. Though both rabbits and cobayes died as a result of subcutaneous injections of an alcoholic solution of naphthol, none showed symptoms of hemoglobinuria. When dogs were similarly treated none died, and he concludes from his observations on these latter that naphthol can not engender serious accidents which may end in hemoglobinuria and death: and further, that naphthol in the doses employed in practice is an excellent remedy for scabies, and absolutely harmless. The ointment used consists of beta naphthol, fifteen parts: lard, one hundred parts: soft soap, fifty parts, and powdered chalk, ten parts. This ointment has given results incomparably superior to all other methods in the cutaneous affections to which dogs are so liable, and which are so obstinate. Itch, eczema rubrum, psoriasis, and auricular catarrh yield, as a rule, very rapidly to frictions with it. More than a hundred dogs have been so treated by M. Nocard: in some the general inunctions have been repeated for eight or ten days without any bad result even when dogs licked themselves. The efficacy of the ointment has seemed to be heightened when after its application the skin was moistened once or twice, at twenty-four hour's interval, with a two per cent. solution of chloral.—*Annales de Dermatologie et de Syphiligraphie*.

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The *Peoria Journal* of recent date contains the following: The French "lady doctors," have carried the day. Henceforth the female medical students will be "mesdemoiselles les internes," and as such they will be admitted to hospitals on the same terms as their male colleagues. Sixty aspirants of the M. D. degree are at present rejoicing in the victory, among them a young negro lady of "plus beau noir," who is said to be one of the most zealous students in Paris. Among the different types of female medical students in France, which a French contemporary describes with much humor, there is only one who has any chance of succeeding in her studies. This is the "serious" student, she who, at an age between 25 and 30, fights for her existence, is simple and reserved, avoids the fashionable "pincenez," holds aloof from both familiarity and prudishness, and works steadily and courageously. It is to be hoped that the majority of the sixty are of her turn of mind, for the description of the rest, who appear to be short-haired and pugnacious damsels, will probably profit little by the new honor conferred on them.

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THE PEORIA MEDICAL MONTHLY, a practitioner's journal. Two dollars a year in advance.

## THERAPEUTIC NOTES.

## SUPPURATIVE OTITIS.

In the course of a report on the progress of otology, by Laurence Turnbull, M.D., in the *Reporter*, we find the following:

A recent Italian writer, E. Gianpiero, advises the following treatment in "suppurative middle otitis, with perforation of drum membrane":

R. Acid carbol cryst.,  $\frac{1}{2}$  dr.  
Aqua dest., fl 3 ozs.

SIGNA.—Keep in a flask for external use.

By appropriate tube, at every irrigation, not less than a quart of the solution should be used, and its application should be made morning and evening. Immediately after the use of the douche three or four drops of the following mixture should be dropped into the middle ear:

R. Glycerini puræ.  
Iodoformi, aa  $\frac{1}{2}$  dr.

After cure of the suppurating process, cicatrization of tympanic membrane should be promoted by painting the margin of the preparation with iodized glycerine, tincture of benzoin, or with the following mixture:

R. Ol. terebinthinæ, 4 drs.  
Iodoformi pulverat, 15 grs. M.

SIGNA.—Apply to the margin of the perforation with brush.

## DYSPEPSIA.

Dr. J. H. Bundy says: If you have a case of indisposition in which your patient throws up everything taken, give

R. Fluid ext. cascaia, 1 oz.  
Ext. of malt, 2 ozs.  
Fluid ext. berberis equifolium, 1 oz.  
Acid hydrocyanic dil., 1 dr.

M. SIG.—Teaspoonful directly after meals, or oftener if there is pain or distress, with belching of gas or wind from the stomach. If with any of the above symptoms there seems to be a sluggish liver, give *nux vomica* in proper quantity.

## FLUSH POWDERS.

Dr. Tilt, in his work on the "Change of Life in Women," recommends the following formula for what he calls "flush powders," to be used by women who suffer much from flushings of the face and other parts of the body, as well as sweatings of the face, hands

and feet, especially at the change of life:

## No. 1.

R. Carmine,  $\frac{1}{2}$  gr. or less.  
Nitrate of bismuth, 1 dr.  
Camphor,  $\frac{1}{2}$  dr.  
Oil of bitter almonds, 2 drops.  
Starch, 2 ounces.

## No. 2.

Carmine,  $\frac{1}{2}$  gr. or less.  
Camphor,  $\frac{1}{2}$  dr.  
Oxide of zinc, 1 dr.  
Attar of opresso, 1 dr.  
Starch, 2 ozs.

## SCIATICA.

Dr. James E. Wilson (New England Medical Monthly) recommends—

R. Chloral Hydrat, 3 dr.  
Bromide of soda, 3 dr.  
Morphia sulph, 6 gr.  
Quinia sulph, 54 gr.  
Pulv. camphor,  $\frac{1}{2}$  dr.  
Elixr taraxicum comp 6 ozs.  
Tinct. aconite, 24 drops.

M. SIG.—A dessertspoonful every three hours until relieved.

## HEMOPHILIA.

Professor Roberts Bartholow recommends—

R. Acidi gallici,  $\frac{1}{2}$  dr.  
Acidi sulphurici dilut 40 min.  
Tinct. opii deod, 20 min.  
Infus digitalis, 2 ozs.

M. SIG.—Two teaspoonfuls every three hours.

## ACUTE PLEURISY.

Professor Da Costa often orders—

R. Tinct. Aconiti rad. 30 min.  
Potassi acetatis,  $\frac{1}{2}$  oz.  
Morphia sulphatis,  $\frac{1}{2}$  gr.  
Liq. potassi citratis, 2 ozs.  
Syrupi tolu, 1 oz.

M. SIG.—Two teaspoonfuls every three hours.

## CHILBLAINS.

R. Tinct. iodi, 10 min.  
Acidi salicylici, 10 gr.  
Tinct. benzoini comp, 1 oz.

M. SIG.—Use externally.

## NEURALGIA.

R. Tinct. aconiti, 8 min.  
Tinct. gelsemii, 12 min.  
Ext. cimicifugæ fld.  $1\frac{1}{2}$  oz.  
Spts. etheris comp,  $\frac{1}{2}$  oz.

M. SIG.—One teaspoonful every hour.



# THE PEORIA MEDICAL MONTHLY.

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## EDITORIAL.

### A RETROSPECT OF THE YEAR 1885.

We had partially written an article with this heading, but finding the same ideas so much more elegantly expressed in the editorial pages of our brilliant contemporary, the *Maryland Medical Journal*, that we concluded to give our readers an exchange of editorial matter this month.

“All along the journey of life positions are reached from which the traveller may look back over trodden footsteps to review the progress made. The retrospect may serve the double purpose of strengthening his faith in achievements won and his courage for those ahead of him. The sum of human endeavor is measured by the results of efforts expended and the forces in reserve for subsequent outlay. Thus, by contrasting the work done with that which awaits him, one is preparad to renew his energies for duties ahead.

At this season of the year it is eminently proper that professional workers should take stock of the year's returns. What have I done and how stands my stock in trade at the end of the year? This is a pertinent question for each one to ask. It is not to be presumed that each one is prepared to give a favorable answer to such an inquiry. It is too true that the professional hive contains its drones; but, as a rule, the medical profession is remarkable for its energy, activity and untiring industry of its many members. Whether impelled by force or necessity, habit or inclination, medical men, as a class do vast sums of labor and

achieve important results, whether measured by the standard of their services to the sick, to their professional interests, or to science. The medical profession has a record for its humane and beneficent labors which, when measured by the standard of usefulness to society, places it in the highest rank among human avocations. It is a record of which each physician, however humble his sphere may be, should feel that he has had a part in making. No higher spirit should actuate a physician than the consciousness of knowing that he has worked faithfully and earnestly in professional duty and that he has contributed to the alleviation of suffering humanity. It may not be reserved for each member of the profession to add largely to the stock of scientific knowledge or to write his name among the great men in science, but each and every practitioner of the healing art is in duty bound to contribute his mite to the perfection of the system of scientific results. In the development of scientific progress it is the multitudinous host of individual skilled observers who must flood the world with precise individual observations. The age in which we live is one of intense criticism and experiment. It is within the power of the individual to aid in this work of precise observation and test. The science and the practice of medicine are undergoing a state of transition. The immense mass of accumulated knowledge is as yet a heterogeneous pile of rubbish in which the facts of medicine are hidden and from which they must be gleaned by the united labor of many individual workers.

Looking back over the progress of the year the profession has much to encourage it in its earnest labors. The year has been by no means an idle one. In each department of the science practical results have been presented which have added to the fund of accumulated facts. Looking over the literary field we observe a great display of literary effort in book-making, in compilations, and in journalistic efforts. The year has introduced to the profession several medical works of decided value, which appear in print for the first time, whilst new editions of well-known works vie with their new competitors. It seems to us that more than the usual number of monographs has appeared during the year. Among the Journals several new publications have entered the field for professional favor, whilst several which were once known to fame are now known only in deed not in name. In the department of surgery the use of antiseptics has been a favorite subject for discussion, and, at the present time of writing, the bi-chloride solution holds the vantage ground. Anæsthetics have not fallen into disrepute or lost in interest. Local anæsthesia has attracted well merited attention and gives promise of encouraging results. In operative surgery

deep interest has centered upon the various procedures within the cavities of the body. A triumph was recorded early in the year in the removal of a glioma from the cerebrum. The abdominal cavity has been ruthlessly invaded by the scalpel with results which astonish the imagination. The record of the year in abdominal surgery cannot be excelled in achievements by any other character of medical or surgical work.

In the practice of medicine antipyretics have received a large share of attention and criticism: whilst materia medica and therapeutics have brought to notice several agents which further investigation may deem worthy of a permanent position among the resources of the healing art.

The epidemic of cholera in Southern Europe has kept up the interest in bacteriological studies and led to the introduction of conflicting theories in regard to the etiology, prevention and treatment of this disease. The practical outcome of this study has been a thorough investigation of disinfectant agents, and an increase of confidence in disinfection and cleanliness as the means of combatting the disease. Marked attention has been given to sanitation throughout the large American and European cities during the year with a practical result in the reduction of the death-rate from all zymotic diseases. Whilst our own country has been spared the horrors of the cholera scourge, and of the small-pox epidemic which has decimated our neighbors in Canada, the Plymouth epidemic has fallen upon a small community with such power as to teach the importance of attention to the local sanitary condition of all small towns and cities.

The year records the usual number of deaths in the profession. Many honored and esteemed laborers in professional work have entered into the rest prepared for the just, leaving behind the memory of their lives and deeds, and the admonition that the harvester is ever near at hand to gather in the golden blades. The births into the profession have exceeded its deaths. Each year the profession is reminded of the loose and irregular methods which prevade our educational systems. We are unable to record any satisfactory progress in the direction of correcting an evil which is sapping the vitality and influence of professional usefulness in our country. A few of the states have succeeded in securing the passage of laws regulating the practice of medicine within their borders. In Pennsylvania, Virginia and West Virginia a much needed system of protection has been secured.

The record of the year has been marked by a controversy on the subject of the International Medical Congress which has been a humiliating spectacle to the fair-minded members of the profession. We have witnessed an upheaval of demagogism and petit jealousy which should find no encouragement in profess-

ional opinion. The differences which have divided the profession on the Congress controversy have been unwise and unnecessary. They have taught no important principle of ethics, and have cast lasting discredit upon the fair name of American medicine.

We have freely expressed our views on this subject in the interest, we believe, of scientific medicine and not out of consideration for the ethical points raised. Ethics are rules of conduct, not theoretical trueisms which have no force in action. The science of human duty is broad, liberal and tolerant, not a fixed code which prescribes opinion by rules more rigid than the Inquisition.

We cannot close our remarks without turning attention to the faithful work in progress in France, in the laboratory of the eminent bacteriologist, M. Pasteur. The old year may ring out before the practical value of M. Pasteur's experiments have been fully demonstrated, but we may look to the year upon which we are about to enter for the full realization of the fact that in the line of bacteriological investigation we have the promise of the most important achievements which science can render to humanity."

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### NOTES AND COMMENTS.

The vapors of nitrous ether are recommended by M. Peyrusson as a disinfectant and antiseptic. They have neither a disagreeable nor a hurtful smell.

A physician in Maryland put a human skull in a tree for safe keeping during a temporary absence and forgot it. When he thought of it again and went to get it he found that a sparrow had taken possession and raised a family in it.

From statistics collected in the abattoirs of Munich and Augsburg, Strauss has found that no more than one calf in 100,000 is consumptive. The danger of conveying consumption with vaccine obtained from these animals is, therefore, slight.

The value of vaccination is illustrated by the registers of an old hospital in Prague, where the mortality from small-pox from 1670 to 1815, that is, in the pre-vaccination period, was 27 per cent., while from 1815 to 1885 it had been only 4.53 per cent.

A newspaper exchange says: A cure for delirium tremens has been discovered in an alkaloid extracted from pickled cab-



bage. This is the roundabout scientific way of getting at it, but human instinct arrived unerringly at the same result centuries ago when it developed sauer kraut.

Dr. Adam Clark, who had a strong aversion to pork, was called upon to say grace at a dinner where the principle dish was a roast pig. He was reported to have said: "O Lord, if thou canst bless under the gospel what thou didst curse under the law, bless this pig."

Oleoze, the favorite German preparation for disguising the taste of the most unpleasant remedies, is said to have this composition: One part each of the oils of lavender, cloves, cinnamon, thyme, citron, mace and orange-flowers: three parts of balsam of Peru, and 240 parts of spirits.

The brain weight of man exceeds that of all animals except the elephant (4,500 grammes), and the large Ceteceæ (2,500 grammes). The brain weight of the largest apes is hardly a third of man's. Professor Bischoff's data comprise the weights of brain of 559 men and 747 women.

Boston has gone crazy over the mind cure and is about to erect a temple to it that will cost \$100,000. Now this is something like it. We do not see why they should call it a temple, though. Why not erect a hospital and try Tyndall's "prayer gauge" at once. This would be something like it.

The Germans have nearly stamped out small-pox. In the years 1870-1874 the number of deaths from the disease per 100,000 inhabitants in London, Paris, Viena, Prague and St. Petersburg was 101.05. In Berlin, Breslau, Hamburg, Munich and Dresden during the same period it was but 1.44.

A mad dog ran through the streets of Newark, N. J., some days ago, and bit several children. Divers and sundry Americans interested in the claims of Pasteur, the French scientist, who has made hydrophobia a specialty, have raised \$1,000 to defray the expense of their transportation to France and for their maintenance while there, and the children were sent at once to Paris under the care of Dr. Billings. This is a blow aimed at all the madstones in America.

Professor A. Vogel observes that the hemlock plant which

yields conune in Bavaria, contains none in Scotland, and he concludes that sunlight plays an important part in the generation of alkaloids in plants. This view is confirmed by the circumstance that the tropical Cinchonas, if cultivated in feebly-lighted northern hot-houses, yield no quinine. The formation of tannin seems to be influenced by exposure of the growing bark of the beech or of the larch having been found to increase from the less illuminated to the more illuminated parts.

A Texas doctor gave the *Medical Bulletin* an account of the ease with which doctors are made in that state. He took a six hours' ride with a Texan villager, who asked him a great many questions about the medicines used for certain diseases then prevailing in the locality. On the following week he had occasion to visit a neighboring village, where he found his recent companion with his shingle out as a full fledged doctor. He had graduated in that six miles ride.

BRAINS.—Men of ordinary intelligence can have very large brains. Of 150 brains of Scotch artisans the heaviest was that of a tailor, 62 ounces. The heaviest brain yet known belonged to a brickmaker named Morris, who died in the University College hospital. It weighed 67 ounces. He commenced life as a poacher: could neither read nor write, had a good memory and an itch for politics. The brain of Joachim, the giant, weighed only  $61\frac{3}{4}$  ounces. Borca lays down, at its full development the mean average weight of brain for a man is 50 ounces, and for a woman  $44\frac{3}{4}$  ounces.

When the vaccination inspector was making his rounds on a train from Montreal to Toronto, he accosted a gentleman in the Pullman car with the usual question: "Have you been vaccinated?" The gentleman, who had very convincing evidence of a three weeks' development of the operation on one of his arms, offered to let the inspector feel the sore places through his coat sleeve. The inspector, however, compelled the gentleman to remove the coat and shirt sleeves in order that he might be satisfied about the genuineness of the vaccination, stating that travelers had attempted to mislead him by sewing two or three buttons in their sleeves.—*Chicago Times*.

A Merry Christmas and a Happy New Year to every reader of the MONTHLY. May the coming year be lacking in the disappointments, and double the pleasures and successes of the past.

The outlook for the future of the MONTHLY was never brighter than now. The number of our readers is constantly increasing, and the original department is better with each succeeding issue. We promise that every number will be better than the last, until the "standard of our high ambition is attained."

Many cases of heroism occurred in the city of Saragossa, Spain, during the recent cholera epidemic. Every citizen gave money, food or labor to the suffering. A poor washerwoman, bringing home clothes to a lady whom she found in a state of collapse, in which it was impossible to warm her, threw off her dress, jumped into bed, took the dying woman into her arms, and chafed the clammy limbs until circulation was restored. When the disease had spent itself the Spanish government offered rewards to the principal officials, who promptly refused them. It then betowed the grand cross of the Order of Benificence on the entire city. This cross is given only to a few individuals, who have risked their lives for the help of others: there is no order more highly valued in Spain. Never before has it been conferred on an entire town.

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### BOOK NOTICES.

AN ATLAS OF CLINICAL MICROSCOPY.—BY ALEXANDER PEYER, M.D. Translated and edited by ALFRED G. GIRARD, M.D., Assistant Surgeon U. S. A. First American from the manuscript of the second German edition with additions. Ninety plates with one hundred and five illustrations, chromo-lithographs. Square, 8vo. Cloth: pp. 191. D. Appleton & Co., New York. 1885. Price \$6.00.

There is probably no work in any language that will prove of as much real service to the beginner in Microscopy, as the one before us, and this value is due to the number and excellence of the plates with which it is literally crowded. One ordinary plate

is often worth ten pages of explanation; who then can reckon the assistance lent by a life size, well colored plate such as we have here? We have studied microscopy under an excellent teacher, but even he failed to furnish us with as good, clear ideas of microscopical objects as we have in these plates. Any physician with a good microscope can become almost an expert from the study of this work alone.

The work consists of the following parts:

- I. Microscopic examination of the Blood.
- II. Microscopic Examination of the Mammary Secretions.
- III. Microscopic Examination of the Urine.
- IV. Microscopic Examination of the Sputum.
- V. Microscopic Examination of Intestinal Contents.
- VI. Microscopic Examination of the Contents of the Stomach.
- VII. Microscopic Examination of Fluid Contents of Abdominal Tumors.
- VIII. Microscopic Examination of the Secretions of Female Sexual Organs.
- IX. Various micro-organisms provoking Disease.

The author has given especial attention to spermatorrhœa, which he believes can be diagnosed by means of the microscope. The text accompanying these plates is short and to the point. Koch's tubercle bacillus is well illustrated, and the methods of preparing phthisical sputum for examination fully explained. This work should be in the hands of every physician who desires home or self instruction in microscopy.

#### CLIMATOLOGY AND MINERAL WATERS OF THE UNITED STATES.

—BY A. N. BELL, A.M. M.D., Editor of the *Sanitarian*, etc., etc. With maps, illustrations and many tables. 8vo, cloth; pp. 386.

DISEASES OF THE LUNGS (OF A SPECIFIC NOT TUBERCULOUS NATURE), ACUTE BRONCHITIS; INFECTIOUS PNEUMONIA, GANGRENE, SYPHILIS, CANCER AND HYDATID OF THE LUNG.—BY PROF. GERMAIN SEE, Member of the Academy of Medicine, and of the Faculty, Physician to the Hotel Dieu, Paris, France. Translated by E. P. HURD, M.D. With appendix



by Geo. M. Sternberg, M.D., and Prof. Dujardin Baumetz. 8vo, cloth; pp. 398.

DIAGNOSIS OF DISEASES OF THE BRAIN AND OF THE SPINAL CORD.—BY W. R. GOWERS, M.D. F.E.C.P., etc., etc. 8vo, cloth: pp. 300.

These three works comprise the October, November and December volumes of *Wood's Library* for 1885, and close the sixth and we believe the last series of this great undertaking.

The fortunate possessors of *Wood's Library* complete have a library in every sense of the word and one that will always be of value. The range of subjects has been almost as wide as that of medicine. All special branches, Surgery, Gynecology, Ophthalmology and Otology, Pharmacology, Botany, Microscopy, Legal Medicine, Chemistry, have volumes devoted to their consideration. The price has been wonderfully low, but we notice is being advanced.

The volumes above noted need no further introduction, for we believe every physician in the country acknowledges the worth of this great library.

CLINICAL NOTES ON UTERINE SURGERY, with special reference to the management of the sterile condition. BY J. MARION SIMS, A.B. M.D., etc., etc. Memorial edition: 8vo, paper: pp, 401. Wm. Wood & Co., New York. 1886. Price \$1.00.

No library should be without a copy of this classical work. The style of Dr. Sims is a model of simplicity and strength.

PRACTICAL SUGGESTIONS RESPECTING THE VARIETIES OF ELECTRIC CURRENTS, AND THE USES OF ELECTRICITY IN MEDICINE. With hints relating to the selection and care of electrical apparatus. BY AMBROSE L. RANNEY, M.D., etc., etc. 12mo, cloth; pp. 150. With many plates. D. Appleton & Co., New York. 1885.

This volume is made up from a series of lectures delivered before the classes of the Medical Department of the University of Vermont, and published in the *New York Medical Journal* during the past year. In their present shape they will prove very useful for ready reference. The author is well known as an able

writer on nervous diseases and his previous works have met with a hearty reception. The title explains the aim and contents of this work.

CUTANEOUS MEMORANDA. BY HENRY G. PIFFARD, A.M. M.D., etc. Third edition: 32mo, cloth; pp. 264, with index. Wm. Wood & Co., New York. 1885. \$1.00.

VENEREAL MEMORANDA. A MANUAL FOR THE STUDENT AND PRACTITIONER. BY P. A. MORROW, A.M. M.D., etc. 32mo, cloth; pp. 332. Wm. Wood & Co., New York. 1885. \$1.00.

These handy little volumes belong to Wood's series of Pocket Manuals, and will be found very convenient for hasty reference. The student will be particularly well pleased with them.

OFFICIAL FORMULÆ OF AMERICAN HOSPITALS. Collected and arranged by C. F. TAYLOR, M.D., Editor of the *Medical World*. 16mo, cloth; pp. 238. Published by *The Medical World*, Philadelphia. 1885. Price \$1.00.

The pharmacopœias of the various large hospitals of this country must contain much that is of well proven value, and their formulæ cannot fail to furnish many useful hints for private practice. Dr. Taylor has done a good work in collecting them into an available shape.

THE PEDIGREE OF DISEASE. Being six lectures on Temperament, Idiosyncrasy and Diathesis, delivered in the Theatre of the Royal College of Surgeons in the Session of 1881. BY JONATHAN HUTCHINSON, F.R.S., etc. 8mo, cloth; pp. 112. Wm. Wood & Co., New York. 1885.

EPITOME OF DISEASES OF THE SKIN. Being an abstract of a course of lectures delivered in the University of Pennsylvania during the Session of 1883-84. BY LOUIS A. DUHRING, M.D. Reported by Henry Wile, M.D. 16mo, cloth; pp. 130. J. B. Lippincott Company, Philadelphia. 1885. Price 60 cents.

A very useful little work for hasty reference.

MILK ANALYSIS AND INFANT FEEDING. A Practical Treatise on the Examination of Human and Cow's Milk, Cream, Condensed Milk, etc., and Directions for the Diet of Young Infants. BY ARTHUR V. MEIGS, M.D., Physician to the Pennsylvania Hospital and to the Children's Hospital, etc., etc. 12mo, cloth; pp. 102. P. Blakiston, Son & Co., Philadelphia, Pa. 1885. Price \$1.00.

A valuable contribution to a subject which has in the past received too little attention. Dr. Meigs' experiments and analyses have done much to settle disputed points in the composition of milk and to determine the best methods for the artificial feeding of infants.

ESSENTIALS OF VACCINATION: A Compilation of Facts relating to Vaccine Inoculation and its Influence in the Prevention of Small-Pox. BY W. A. HARDAWAY, M.D., Professor, etc., etc. Small 12mo, cloth; pp. 146. J. H. Chambers & Co., St. Louis, Mo. 1886.

We commend this work especially to those physicians who profess no faith in the efficacy of vaccination, and to that larger class whose faith is wavering. Its statements are plain and based on statistics covering sufficient time and a sufficiently large number of cases to make them incontrovertable. Every physician should have it for the rules and suggestions laid down for the operation of vaccination. It is also a good work to put in the hands of intelligent laymen.

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#### NOTICE TO SUBSCRIBERS.

Receipts for the month have been omitted. We hope all to whom statements have been sent will remit at once, if they have not already done so. All errors in statements will be cheerfully corrected, as we do not wish to overcharge anyone. If anyone is unable to remit at this time, please send us word and we will be glad to wait your convenience. All who can pay will greatly oblige us by prompt payment, as we wish to close our books for the year and begin *square with the world*.

# THE PEORIA MEDICAL MONTHLY.

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## CLINICAL LECTURE.

### HYSTERIA—OXALURIA—INCIPIENT LOCOMOTOR ATAXIA—GASTRALGIA.

BY PROFESSOR J. M. DA COSTA, M. D., PHILADELPHIA, PA.

#### PECULIAR CASE OF HYSTERIA.

It is with great satisfaction, gentlemen, that I bring this case before you to-day. You will remember this woman as the case of hysteria that I had before you some weeks since, when I told you the patient did not seem to have any desire to *sham*; that the affection was, in her case, a real disease. She would be frequently seized with uncontrollable paroxysms of twisting and twitching, screaming and would fall to the floor, not, however, losing consciousness. You may remember that when I applied the stethoscope to her chest one of these *spells* was thereby excited and putting her hands to her head she screamed maniacally for some seconds, the whole system, the while, evidencing great perturbation. I bring her before you to-day, I say, with great satisfaction, for our therapeutic procedures have produced wonderful results. She was ordered two grains of valerianate of zinc thrice daily, and she was treated for an erosion and laceration of the cervix uteri that was found. To-day she walks well, having previously suffered from hysterical paralysis; there is no tremor, no loss of power; she has gained flesh, and has had no "spells" since the beginning of treatment until about one week



ago, when she had a very light attack. Her tongue is still somewhat coated and her bowels costive. We have had here much more marked and rapid improvement than we had any right to anticipate; this I attribute to the zinc and to the local treatment. As the tendency towards these attacks is now broken up, we can abandon the zinc and resort to remedies better calculated to improve the general health and build up her nervous system. We will order for her

R.	Liq. arsenici chlor.,	5 drops.
	Tinct ferri chlor.,	15 drops.
	Syr. simpl,	10 drops.
	Elixir simpl,	ad 1 fl. drachm.
S.	Thrice daily, after meals. M.	

For the costiveness we will give her, every night,  $\frac{1}{10}$  grain aloin and  $\frac{1}{12}$  grain extract belladonna, with two grains of rhu-barb, If this acts inordinately, we will only give it on alternate nights.

#### OXALURIA.

Here is a case presenting some interesting features. This young man, aged 29, has prepared his own history and from it we learn that there is some vague history of kidney disease on his mother's side: his digestion is poor, he is costive, he belches, and suffers from acidity, from directly after to two or three hours after meals. He complains of soreness in the epigastrium, which is not aggravated by taking food; he is loosing flesh and has a curious appetite—when he sits down to the table he feels as though he could not eat fast enough to satisfy his hunger, but he is soon satiated and becomes distended. His sleep is disturbed, and he complains of soreness about the back. He has chilly sensations and his breathing is, at times, oppressed and irregular. He has a dull, throbbing pain in the temples and an occasional sensation as of clamps about the heels. He sweats all over the body. I wish particularly to call your attention to a marked symptom in this case—his great depression mentally: he also complains of impotency, extreme difficulty in concentrating the mind on one subject; he has no vertigo or headache. The urine has a specific gravity of 1021 to 1036; it is dark red, but contains neither albumen nor sugar, it is full of urates and he has a constant desire to urinate: he passes about forty ounces

per day. He complains of roaring in the head and floating specks before his eyes, not present when he feels at his best. His heart is somewhat irritable, and there is a soft cystolic left basic murmur. The tongue is large and flabby, showing the marks of the teeth. His liver and spleen are normal and there is no œdema. This case impresses me as one of oxaluria, which is a form of non-assimilation, of non-oxygenation of food. In nearly all such cases we find excessive quantities of urates, but in order to clear up the diagnosis, beyond any possibility of doubt, we must examine the urine under the microscope. The great mental depression, the roaring in the head, defective eyesight and dyspeptic symptoms (sometimes very slight) are all significant of oxaluria, as is also the constipation. But the urine offers the most characteristic signs. In all these cases the urine has a high specific gravity.

In forming a prognosis, we must always take into consideration, the occupation and habits of the patients. This disorder is very common among those who are industrious and lead sedentary lives, among brain workers, and particularly, if to a sedentary life, we conjoin the excessive use of tobacco: the gouty diathesis also plays a prominent part in its causation. Sexual abuse, as excessive venery and masturbation are common causes. We must have all these facts in mind, because, though we may cure a case, it will not remain cured unless we remove the cause. In the treatment we must insist on easily digested food. In place of three meals daily he should take four and eat sparingly at each. He should consume but a moderate quantity of underdone meat, relying mainly on green vegetables, fish and oysters. Sugar must be forbidden. He may use tea and coffee, indeed they are said to have a tendency to limit the disease. He may also use milk, but no wines or liquors. Active exercise is a most important therapeutic procedure, particularly such as tends to produce a free action of the skin, as brisk walking and friction with a coarse towel, the action of the skin in burning off this non-oxygenated nutriment will greatly help our other measures. Of drugs, nitro-muriatic acid is the best in this condition; it acts partly, no doubt, by aiding digestion, partly by its alterative action on the liver, and on account of the chlorine which it contains, directly on the blood as well. We

will give this young man five drops of the strong acid, diluted in a wine glass of water, thrice daily, to be taken through a tube, before meals; and we will also give him  $\frac{1}{60}$  of a grain of strychnia thrice daily. Cocoa will also prove valuable in such cases. We must also attend to the bowels, and for this purpose small doses of the salines will prove most efficacious. He will take from one to two drachms Rochelle salts, two or three times a week.

#### INCIPIENT LOCOMOTOR ATAXIA.

This stout blacksmith, aged 46, presents an exceedingly interesting case for our study. He complains of pain, originating in the back and shooting down his legs, which are present about one-third of the time, being absent the other two-thirds; he will have them for a few days and then they will vanish; they are not influenced by the weather. It is sharp and griping at times, while, at others, it is as though a dull knife were being drawn over the bone. This pain never ascends to the arms. He can walk well, as you see, and kick both legs with considerable force. He can walk equally well with his eyes shut or with the head thrown back and the eyes fixed on the ceiling. He stands perfectly well with the feet in juxtaposition and the eyes closed. His urine has a specific gravity of 1010; it is acid, and there neither albumen, sugar, nor sediment. He has no dyspepsia, though he is somewhat costive. There is no heart lesion; the tongue is coated in streaks; his eye-sight is good; he has very little headache and very little vertigo. No causeless vomiting. There is a doubtful history of syphilis when he was a very young man. He has a very peculiar state of the pupils; they are contracted, but not at all influenced by light; yet when he brings into play the powers of accommodation, the pupils do contract and dilate. This is called the Argyle-Robinson pupil, after the two men who first observed this peculiar condition. Ophthalmoscopic examination reveals sclerosis of the fine arteries and dilatation of the veins of both retinæ. Patella-tendon-reflex is almost abolished on the left side and entirely absent on the right. Here we have the very earliest possible stage of locomotor ataxia, the diagnosis being made solely from the condition of the vessels of the retina and the state of the pupil, in conjunction with the absence of the tendon-reflex. This Argyle-

Robinson pupil is one of the most significant signs of the early stages of locomotor ataxia, and when found in connection with absence of the patella-tendon-reflex and pain in the lower extremities, the diagnosis is sure. There is no disturbance, in sensation or locomotion in this case yet. When we see a case so early we ought to make an attempt at radical treatment, and as we have some idea of a specific history, we will order this man twenty grains of iodide of potassium, thrice daily, commencing with ten grain doses, to see how his stomach will tolerate it, and increasing to twenty. Following this we will give him nitrate of silver.

#### GASTRALGIA.

Here is a woman who complains of epigastric pain, coming on two hours after meals and neuralgic in character, and lasting for an hour. She is not costive; does not vomit, but suffers some from acidity in the morning. She thinks, though she has never tried it, that she would not suffer from this pain if she abstained from food. It is not any more severe after a hearty than after a light meal, and the epigastrium is not tender on pressure. All her functions are normal. Here we have a case of gastralgia. We rarely see a case so purely nervous, where there is so little gastric derangement. It is a most difficult disease to treat and you must not make light of it; it will sometimes linger for years. The most useful drug that I know of in these purely nervous cases is *cannabis indica*, of the extract of which we will order  $\frac{1}{8}$  grain along with  $\frac{1}{40}$  grain of arsenite of sodium; the more the case approaches the nervous type, the more useful will be the arsenic; while, when there is much gastritis, bismuth and similar preparations will do more good. The diet must be exclusively milk, or at the most, if this be too irksome, milk toast and soft boiled eggs. *Cannabis indica* is a drug that is very likely to be adulterated, and you must be careful to procure a pure article, else you will be disappointed in its results.

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## ORIGINAL COMMUNICATIONS.

## THEORIES OF THE PRODUCTION OF THE SEXES.

BY SILAS HUBBARD, M. D., HUDSON, ILL.

Dr. John Stockton Hough, of Trenton, N. J., recently in writing to me says: "I am making a collection of books and pamphlets on generation, production of sexes, etc., having now about 5,000." He further says: "So far as my reading goes you were the first to announce the theory that the sex of fœtus depends on the degree of maturation of the ovum at the time of fecundation." I would add that I believe every thing that has been written on the subject of the maturation of the ovum and the times of the menses and intermenstrual periods as relates to the sexes begotten, descended from what I published in the *Buffalo Medical Journal* from 1850 to 1855, inclusive; and now I propose through your valuable MONTHLY to make some additions on the above subject to what I have heretofore published. I will here say that I shall proceed according as thoughts occur to me, and not according to any system. In this paper I shall repeatedly refer to remarks of Dr. Hough, all of which can be found in the *American Journal of Obstetrics and Diseases of Women and Children*, vol. xvii., February, March, May and June, 1884.

I will, then, here say first that tight lacing of women is so oppressive to the fallopian tubes that they are not likely to carry semen up to the ovary, consequently such women are more likely to produce girls than boys and likely to be unprolific.

Some women are so weakly that their fallopian tubes will not take the semen up to the ovaries, and their husbands are so weakly that their spermatozoa are so weak they will not make their way up the tubes to the ovary, therefore they produce no boys. If such parents insist on having a boy, tell them to have coition only shortly before the menses, and then at night on going to bed, that the semen may gravitate to the fundus of the uterus and find its way up the fallopian tubes to the ovaries. I have known some cases of sterility of the woman to be cured by such a proceeding.

The sexual propensity of women is usually stronger shortly after the menses than before, which accounts for many cross and

feverish women who might have boys, having nearly all girls; they are not willing to accommodate their husbands only when it accommodates themselves, consequently the most of their children are girls, while the good-natured woman with an equally vigorous constitution has more boys.

Occasionally an extrauterine foetation is a female, and this is because the ovum was arrested from descending into the uterus until it became old and mature, and if thus it is impregnated it grows to be a female. Quadrupeds very rarely have extrauterine foetations, because the uterus and tubes lying horizontally the ovum does not have to travel up hill, and because they always obey the laws of nature. They never have placenta prævia, because of their uterus lying horizontal and because they obey the laws of nature. They are more certain of impregnation than are women, because their uterus and fallopian tubes lay horizontally, and neither ovum nor semen has to travel up hill, and because they do not disobey the laws of nature.

Occasionally the child in a placenta prævia case is a boy: this is because the ovum was detached from the ovary in a very immature state and hastily transferred through the fallopian tube into the cavity of the uterus, and being impregnated while in that immature condition, and falling low into the neck of the uterus, a placenta prævia case is produced and the child is a boy, and such accident in which the child is a male is caused by excessive sexual intercourse shortly before the courses, which aids to detach the ovum from the ovary and hurry it through the fallopian tube in an immature state; but where the child is a female in a placenta prævia case the accident is usually caused by excessive intercourse shortly after menstruation, causing the mature ovum to fall too low, where it makes its attachment, and in very many instances the intercourses are so excessive that they cause the ejection of the ovum. Pleasurable coition of the woman produces an action of the uterus and fallopian tubes towards the ovary; but excessive intercourse becoming disagreeable reverses the action and produces an expulsive effect, therefore a rape being repulsive to the woman would likely be unfruitful.

All sexual intercourse if agreeable to the female has a tendency to hasten and invigorate the grasping of the ovary by the fimbriated extremity of the fallopian tube, and if an ovum is

formed, to aid in detaching it from the ovary and conveying it into the fallopian tube; however, shortly before such menstrual period the fimbriated extremity of the tube ordinarily does grasp the ovary and helps to detach the ovum and convey it into the uterus even without sexual intercourse. and normally it always does this, but occasionally this order of exercise is not performed and then the ovary is liable to become diseased by the ovum dying within it, or even peritoneal irritation produced by the ovum dropping into its cavity. During menstruation and shortly after, the action of the fallopian tubes are towards the uterus, to convey the ovum into the uterus.

One of the reasons that illegitimate children are more likely to be females is that the mother is more likely to have intercourse at that time which pleases herself most, which is usually shortly after menstruation; however, American women are so virtuous that but very few of them would risk the impregnation of an ovum out of wedlock, and even then they are so smitten in conscience that the fallopian tubes would fail to cary the semen up the ovary, which would be another reason for the children being females. Unprincipled women who encourage impregnation out of wedlock, expecting to make their fortunes, are more likely to have boys than in ordinary cases of illegitimacy. The desire to conceive offspring encourages an action upwards of the uterus and fallopian tubes to convey spermatozoa to an ovum in the ovary, if there is a graffian vesicle there.

The Israelites have a law given through Moses that a man shall not have intercourse with a woman during her menstruation nor short of seven days after, (Lev. 15, 19, 24, also 18, 19); also if a woman is irregular, having a show of blood every few days, she shall not have intercourse during such irregularity, (Lev. 15, 25, 28.) I suppose some of the reasons why they should not have intercourse during menstruation were that coition then sometimes reverses the action of the fallopian tubes, thus sometimes causing extrauterine conceptions, also sometimes carrying menstrual blood to the ovary to the damage of the health of the woman, for the sake of cleanliness, and also that the offspring should have the distinct characteristics of one sex or the other. Some of the same reasons, and also to permit her to recover, would apply to the woman who is having a show of

blood every few days; and that she shall not have intercourse short of seven days after menstruation is to make them temperate in sexual intercourse, and also largely increase the prospects of their begetting a large majority of boys, as they were to be a nation of warriors, and they could save the captive virgins to cross the breed for the benefit of the nation. So far as I have consulted the ancient and modern history of the Jews there have always been a large majority of males among them.

The Mosaic law makes the following difference in regard to a mother after the birth of a male or female child: After the birth of a male child "she shall be unclean seven days" (Lev. 12: 4); "but if she bear a female child, then she shall be unclean two weeks, as in her separation; and she shall continue in the blood of her purifying three score and six days." Dr. Hough gives as the reason for the above difference that the placenta which belongs to a girl is larger usually than the placenta which accompanies a male child. I will admit his statement, but I will account for its being larger and more expanded on different principles from what he does, viz., the ovum which grows to be a male is fecundated while in the fallopian tube or ovary, consequently it attaches itself to the fundus of the uterus as soon as it has entered the uterus, where it does not have as much room to expand and grow as does the placenta which accompanies the female child, which is ordinarily situated nearer the center of the uterus where it has more room to expand; and it being larger and more expansive, she would on an average flow more and longer than after the birth of a male. According to the law as given by Moses there was a particular honor bestowed on the first male child born in a family; I suppose that one reason was that temperance, industry, vigor and health favor the production of boys; however, both parents can maintain all these excellences and have girls if they choose.

Dr. Hough gives some respectable authority as saying that fat sheep produce more ewe lambs than males, while lean sheep produce more males. I will say that there are some grounds for believing the statement. Fat women produce more girls than boys, and I will give the reason why. It is because the pressure of the fat not only retards the progress of the ovum into the uterus, but also retards the progress of the semen up the



fallopian tube to the ovary, consequently the semen rarely reaches the ovum until it arrives in the uterus in a very mature state. Fat women are frequently sterile.

I recently interviewed a number of horse breeders in this vicinity. They all agreed that mares impregnated in the beginning of heat usually produced males, and those in the latter part of heat produced females; but they preferred the middle of heat because that time would prove more certain. Excessive service of the stallions caused them to be uncertain, and when they did beget colts they were usually females, and I will give the reason why, viz., their excessive congress so weakened their spermatozoa that they could scarcely impregnate an immature ovum, consequently the ovæ they did usually impregnate were very mature and hence developed into females.

I will here publish for the first time something important to stock-raisers, viz., the sow which is admitted to the boar on the first day of heat will have a majority of male pigs, but if on the second or third day she will have the largest number of progeny and the sexes will be about equal in number; but if she is admitted on the fourth day, or as she is going out of heat, she will have the fewest number and they will be sows. She ought not to be admitted over half an hour on any day.

I tried some experiments with setting hens. I found that when the first half of a batch of eggs laid by a hen were hatched, they principally developed into hens, but the last half laid mainly developed into roosters. According to my theory the first half of a batch of eggs of the hen turkey would develop into hens mainly, and the last half into males.

It would be well if physiologists would observe in what order the sexes were born of bitches, and sows, and also to observe in what order the sexes lay in the uterus: it might throw some light on the situation of the placenta in women as regards the sex of the child.

So far as I have observed the birth of twins, in women, where they were of different sex the male was always born first, I suppose because they are usually heavier and therefore sink lower in the uterus and therefore engage first, and if one of them was presenting right and the other wrong, the boy would be right and the girl wrong, for the head and shoulders of the boy

being heavier than the same parts of the girl would sink his head to the outlet of the uterus, while the hips of the girl being heavier would be more likely to cause her to present lower extremities or breech first.

It sometimes happens that shortly after menstruation an ovum is cast off which would have grown to be a girl, and in that case spermatozoa might sometimes be retained in the fallopian tubes waiting for an ovum to be formed, and thus impregnation occur seven or eight days after the coition, for the spermatozoa will sometimes live as long in the fallopian tubes as they will in the vesiculæ seminales, hence there is no positive time that a fertile woman, if exposed, can say she is exempt from impregnation. Sometimes an ovum within the uterus which would grow to be a female is fecundated, and very soon after another ovum within the ovary is also fecundated, as a superfetation, and carried by one of the tubes into the uterus, and thus there would result a twin case of a boy and a girl. Ordinarily an ovum is monthly alternately formed in the right and the left ovary. If two are matured and fecundated at the same time they will develop into the same sex and the sex will depend on the degree of maturation of the ova at the time they were fecundated.

[TO BE CONTINUED.]

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## AMENORRHOEA.

BY W. H. TATE, M. D., GREENSBURG, OHIO.

Having read an article in the August number of the MONTHLY on manganese in the treatment of amenorrhœa, by Dr. A. R. Hicks, it reminded me of several cases in my hands treated with potassæ permanganas, one or two of which I will refer to.

About the first of March, 1885, Miss H., a girl about 18 years of age, called at my office for treatment, her menses having been absent for several months, from the effects of getting her feet wet which resulted in suppression of the monthly flow.

Although she had been remarkably healthy previously, and had menstruated regularly, yet at the time she presented herself for treatment there were evident symptoms of decline, viz., ner-

vous chills, a cough characteristic to such ailments, night sweats, emaciation, etc. I prescribed the following:

R. Potassæ permang.,	1 dr.
Aqua pura,	8 ozs.
Dissolve.	

SIG.—One teaspoonful every four hours, commencing a week or ten days before the expected return of the catamenia.

If necessary this amount may be continued for two or three weeks if it does not interfere with the functions of the stomach.

About the latter part of August last Mrs. B., a married woman about 20 years of age, also stated that she had not experienced her menstruation for about three months and applied for treatment. I resorted to the permanganate which was continued for a week or ten days with the most happy result, producing a most copious discharge of the menstrual fluid.

I have since treated quite a number of cases suffering from suppression of the menses and have found the remedy above alluded to, as efficient and reliable as any other that I have ever resorted to for such purposes. All of the cases alluded to yielded very promptly to the drug, which brought about results far more pleasing than I had anticipated.

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## CAPILLARY BRONCHITIS WITH LOBULAR PNEUMONIA.

BY J. E. MARSH, M. D., PORTAGE, WIS.

The following report of a case of capillary bronchitis with lobular pneumonia which occurred in my practice last spring, may be of interest to some on account of the remarkable frequency of the pulse and respiration, with final recovery.

I was called on the eve of March 16, 1885, to see Leroy Simmons, aged 13 months. Previous health had been good to within a few days, since which he had suffered from a severe cold, as the parents described it. They said there had been a good deal of rattling in the lungs for a day or two. He had been getting worse from day to day, and was very bad during the two previous nights.

I found him with symptoms of pain in the head, much pain in coughing, wishes to lie on left side, has the expiratory moan, countenance indicates much suffering, urine scanty, pulse 130, respiration 60, temperature 101. Examination of chest revealed abundant subcrepitant rales over entire chest, with here and there some dry rales; right lung most affected; no dulness on percussion.

Gave potassium bromide and spirits ætheris nitr, with a very little tincture aconite.

March 17.—Patient worse than day previous. Gave in addition syrup rhei aromat to move bowels, and a little F. E. ipecac.

March 18. Symptoms worse. Prescribed the following:

R. Spts. Ætheris nitrosi,	1 drachm.
Syrup ipecac.	
Olei ricini, aa	2 drachms.
Syrup simplicis,	7 drachms.

M. Sig.—A teaspoonful every two to four hours. In addition left digitalis and am. murias.

March 19.—Respiration and pulse more frequent; countenance indicates great suffering. Left tincture opii camphor. to relieve. Continued the medicine of previous day.

March 20.—Failing. Coldness, cyanosis. Ordered heat, friction and brandy. Continued the digitalis and am. murias.

March 21.—Takes but little nourishment—milk from bottle. Respiration more frequent and shallow, and pulse more rapid and feeble. Rattling caused by mucous in lungs can be heard very distinctly. Continued treatment of previous day. Commenced the use of poultices of linseed meal and a little mustard a few days previously and they were continued.

March 22.—Symptoms more unfavorable. Larger quantity of mucous in lungs. Respiration 85; pulse 160. Spells of cold extremities and cyanosis. Struggles hard in a fit of coughing and succeeds in throwing off a large quantity of mucous. Soon appears some better. I remained during the night. Applied large hot onion poultices to chest anteriorly and posteriorly. Gave 10 drops of brandy every hour or two in milk. Instead of paregoric gave tincture opii, f. e. ipecac, and pot. bromide, which relieved head symptoms and gave rest. It would pre-



viously put its hand to its head and roll it from side to side. Profuse perspiration soon commenced lasting two or three hours. As the child was too weak to nurse, I held the nursing bottle containing the milk and brandy and forced it through the tube into its mouth. Gave one drop tincture digitalis and one grain am. carb. every two hours. A few minutes before giving the milk and brandy gave the following:

R. Brandy,	10 drops.
Glycerine,	12 drops.
Quinine,	$\frac{1}{2}$ grain.

Every two hours, alternating with the ammonia and digitalis.

The accumulating mucous embarrassed the respiration more and more, and towards morning I gave 2 grains hydrag. sub-sulph., and as vomiting did not result, I repeated the dose in fifteen or twenty minutes, which caused vomiting, freeing the lungs from large quantities of mucous, but nevertheless the respiration grew more shallow and rapid, counting 100 to the minute; pulse 180 and very weak. Ordered same treatment continued during the day except that the quinine mixture was to be given every four hours instead of two.

March 23.—Respiration rose to 115 per minute, pulse too weak and rapid to be counted. It had as much milk and brandy as it could stand. Onion syrup with a little ipecac caused vomiting two or three times. It coughed up and swallowed a good deal of mucous. Had a large evacuation of mucous from the bowels. For a few hours towards evening it appeared very hungry or thirsty. Gave slippery elm tea to drink for thirst in addition to milk and brandy. At 5 P. M. respiration was becoming less frequent and within three hours had gone down to 80; pulse 155. Applied linseed meal poultice containing mustard during the following night. Gave  $\frac{1}{10}$  drop liq. strychnia at the time of giving ammonia and digitalis. I remained during the night. Patient continued to improve until morning when respiration was 55, and pulse 135.

March 24.—Patient gradually improved and was soon convalescent. Some dullness remained on right side but soon disappeared. Continued treatment with pot. iodide and a tonic mixture containing iron. Patient made a good recovery.

## ANGINA PECTORIS.

BY EMIL BRENDDEL, M. D., CEDAR RAPIDS, IOWA.

In the *Medical News* (Nov. 28, 1885) before me I find a note, translated from the *Bulletin general de Therapeutique*, headed, Cure of Angina Pectoris, which induced me to review four cases of a like disturbance. The afflicted persons, farmers, are two brothers, between the age of 70 and 80 years, and two sons of the older brother between 35 and 40, living 10 or 12 miles from town. In all four I found irregular action of the heart, sharp pain and oppressive feeling of narrowness and coldness near the apex of the heart, which was paroxysmal respecting the pain.

The first case in spring, 1882, to which my attention was drawn, was that of the oldest son of the elder brother, who had given up being treated for his complaint, because of having consulted several physicians without any benefit, and I could not make out the true nature of his complaint by his refusal.

The second case in February, 1884, was his father, 80 years old, who presented the symptoms of a severe bronchitis and that irregular action of the heart, which I treated in the usual way respecting bronchitis and by subsequent use of digitalis, ferrum jodatum and quinia. He recovered from his bronchitis, but the heart's action, though improved in the volume of the beat and rythm showed still one intermission in about 18 minutes.

The third case in June, 1884, was the second son of that gentleman who presented that same irregularity of heart's action and the paroxysmal oppressive feeling of narrowness below the heart.

The fourth case, two months later, was his uncle, about 69 years old, presenting the same symptoms and grasping pain, irregular paroxysms. As I treated these two last cases essentially alike, I will only report the statement of uncle John.

The examination of the urine showed no albumen, no casts, but uric acid and scantiness. The paroxysms of pain irregular, though always towards night. I prescribed

R. Fluid ext. digitalis,	½ drachm.
Kali jodati,	2 drachms.
Tr. scikae,	½ drachm to 1 oz. fluid.

S.—1 drachm ter die, with as much water.

Which increased the volume of the heart's beat, and the flow of urine exhibiting reddish urate sediment.

The third day gave persulphate, quinine et ferri, which had no effect whatever, and I returned to kali jod., digitalis and colchicum, which seemed to mitigate the pain; the urine became more copious and clearer of sediments. The examination of the urine gave nothing abnormal.

But soon he complained of increased pain and sleeplessness. I prescribed -

R	Kali bromat,	4 drachms.
	Tr. digitalis,	1 ounce.
	Glycerine,	1 oz. in 8 oz. fluid.

S.—One-half ounce per die.

Which did tolerable good service, together with local application of morphia, and in addition of kali jodatim was continued for more than three months, at the patient's request, to give him the same medicine in larger quantities. Afterwards they came often and asked for more medicine. The heart acts remarkably—more regular; the pain is gone, only an oppressive feeling left.

Though I was sure of a correct diagnosis in the third and fourth case, for the irregular action of the heart. Of the case No. 1 I have found out but lately, and the second case was veiled by bronchitis. I cannot say that I used the iodide for "modifying the arterial condition," as it is indicated in the above named article of the *Medical News*, neither did I regard the disease as an affection of the coronary arteries of the heart—which idea was entirely new to me, but I took it as a nerve-reflex action, localized on that particular spot—a neurosis. And the cause of that neurosis was what I tried to make out, which after not finding any disorder in the kidneys, nor malaria, I laid it to a rheumatic diathesis or irritating action of the uric acid, which I found in the urine.

That amyl nitrate would relieve the pain was known to me, but I was afraid to leave that remedy in the hands of my patients. That M. Nuchard, the author of that article in the *Bulletin*, refused digitalis, which I employed from beginning to end with the same result, would indeed testify to me the beneficial action of the iodides.

That this disease occurred in one family, if not in all its races; but in regard to the irregularity of the heart's action, is a fact, the explanation of which my Latin does not reach.

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### MALIGNANT PUSTULE.

BY F. W. MOFFITT, M. D., RANDOLPH, WIS.

On the 26th day of May, 1885, a six-year-old daughter of H. Z., German, came in to dinner with a slight scratch on the left side of her nose. She had been playing with some chickens, dead from chicken cholera. She complained of some pain in a short time, and in a few hours a pustule had formed, containing dirty, yellow pus. In a few more hours the pus had become clouded with dark colored masses, and some ædema had set in. By morning of the 27th, the ædema involved the eyelids and whole upper part of face, the pustule had a livid, indurated border, and there was some fever. The parents being averse to running a doctor bill, treated it with local sour-milk applications, and internally some herb tea. The case of course continued to grow worse, and on the morning of the 29th, I was called in.

The history, so near as I could learn, was as I have given above. I found in the seat of the pustule a black crust surrounded by a livid, raised, indurated area three or four lines thick. The ædema had closed both eyes so completely that I could scarcely open them, and had extended into the frontal region nearly to the coronal suture, near which another pustule was forming, and another had formed over the right orbit, about an inch above it. When the crust was removed from the original sore, it revealed an ulcer with a sloping floor, perforated at the bottom by an orifice about the size of a pin hole. By pressing upon the indurated base this orifice gave exit to a bloody pus. There was a general depressed state of the system with a tendency to coma. The urine was acid, high colored and scanty. Evacuations semi-solid and possessing a terrible stench.

From the history and present symptoms I pronounced the case malignant pustule. Excised the ulcers and cauterized. Iron, quinine, and stimulants with carbolized water dressings. Also freely opened a sinus connecting first two pustules.



Prognosis unfavorable, because I thought the pus had already entered the ethmoidal sinuses: hence the head symptoms.

May 30. Case appeared somewhat improved; œdema much less; pulse slower and stronger, but coma still impending.

May 31. Considerable stupor, muscular twitchings, nervous startings; urine retained, and when voided was done so involuntarily, as also were the feces.

From this the case passed very rapidly on a downward course, which resulted in death on the 2d of June.

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## SOCIETY TRANSACTIONS.

### CHICAGO MEDICAL SOCIETY.

Stated Meeting, December 7th, 1885. The President, C. T. Parkes, M. D., in the chair.

*Pneumonic Abscess* was the title of a lengthy and instructive paper by Dr. Edward F. Wells, of Minster, Ohio. He incorporated in his paper the histories of a number of cases which recovered under expectant and medicinal treatment. In an experience with 413 cases of pneumonia, abscesses occurred nine times. In closing his paper, the author said that he had arrived at the following conclusions:

1. The issue of pneumonic fever in abscess is rare, but this rarity has been greatly overestimated.
2. These abscesses vary much in size and are most frequently found at the base of the lung.
3. They may in some instances, after pneumonia, be caused by excessive jarring or other motion.
4. They are usually formed rapidly.
5. In some rare instances the purulent contents may degenerated into a cheesy mass, to again soften, liquify and be discharged.
6. The symptoms and signs are quite distinctive and sufficient for an accurate diagnosis.
7. The majority of cases recover, but in a certain proportion a cure is impossible.
8. Expectant and medicinal treatment, thus far, has given the best results, and the majority of cases should be managed

upon this plan, but, under certain conditions, the most radical measures for relief are not only justifiable but imperatively demanded.

Dr. Christian Fenger said that an interesting point in the paper is, that the author takes the ground of the clinical, and perhaps, the conservative man. Dr. Wells claims that we should not operate on the small abscesses, but only on large ones, as the latter are the more dangerous. Dr. Fenger believed that we should operate on all of them when indicated. Buhl, in Christiania, has operated on nineteen cases in which there were cavities. Up to the present time, we have reports of about thirty cases in which operations have been performed. but only seven of these cases have been such as reported by Dr. Wells, or abscesses incident to pneumonia. Since there have been only seven cases of abscess of the lungs, incident to pneumonia, it stands to reason that these cases were severe ones, and that the abscesses were large. Dr. Fenger did not believe there had been much operating on small abscesses as yet; however, he would advocate it in case these abscesses were accompanied by a fetid bronchitis. There is an abscess-cavity, which Rokitansky calls a chronic abscess, in which there is not connective tissue enough to allow the cavity to close. This cavity is a source of danger to the patient, as sometimes, for one reason or other, septic micrococci gain entrance, accute inflammation or gangrene follows, and the patient dies. In such a condition, we should try to obliterate the cavity. Operative treatment of these abscesses has been so infrequent that we cannot say that it possesses any advantage over medical treatment. The important point to be decided in the future is how to get an understanding of where the danger-line is: how long can we afford to wait and how much strength can we afford to let the patient lose before we operate? It is, perhaps, well to put in a word of warning against operating too early, as we are all aware that patients who recover without an operation do better than those on whom there have been operations. Dr. Fenger said that, in case a cavity gives rise to fetid breath, frequently a fetid bronchitis is developed, and subsequently an inter-lobular pneumonia in the other lung, or in the upper part of the lung in which the abscess exists. Relative to Dr. Well's remark that he never suppresses the cough, Dr. Fen-

ger stated that it is a fact that the cough ceases almost instantly after the abscess is opened.

Dr. R. Tilley said that he could not see of what benefit inhalations of turpentine could be in such cases, as the abscesses are analagous to those which occur in the more external portions of the body, and we never expect to benefit them by using turpentine. He would expect better results from administering this medicine internally, as he had, recently, read that the German physicians are using turpentine very successfully, by giving it internally, in diphtheria.

Dr. Wells, in closing the discussion, said that he wished to recall the attention of those present to the important point, that these abscesses occur most frequently in the lower lobe of the lung, similar to pneumonia. The principal object of his paper was to do what he can to counteract the tendency among the medical journals to advise early operation in pulmonary abscesses. He thought the statistics, so far, do not prove the operative treatment to be superior to the expectant and medicinal treatment, and he thought surgeons were too prone to take the cases into their own hands, and that they do not leave enough to the *vis medicatrix naturæ*.

*A case of Expulsion of a Large Sub-mucous Fibrous Tumor of the Uterus, per vias Naturales, or Colpo-Myomotomy*, was title of a paper read by Dr. J. H. Etheridge. Mrs. A. B., aged 43 years, married 28 years, mother of three children, suffered from menorrhagia for six years, past. She has had frightful hemorrhages, but otherwise she has been healthy. In 1882, the first examination which he was permitted to make disclosed a large submucous, fibrous, uterine tumor, at the top of the fundus uteri, extending one inch above the umbilicus, its lateral diameter equaling its longitudinal diameter. A uterine sound was introduced eleven inches. There was no rectal or vesical disturbance. The only inconveniences experienced were the hemorrhages and a "high stomach." The hemorrhases have repeatedly brought her to death's door, but her recuperative powers were astonishing. Dr. Etheridge then detailed her history for two years, during which time she had had several hemorrhages, which were controlled by sponge-tents, rest and ergot. He detailed also the treatment by a homœopathic physician, which had

consisted of incisions into the cervix uteri, and the administration of sulphuric acid and fluid extract of *hydrastis canadensis*, the latter remedy being extolled as a sure cure for uterine fibroids. On November 12, 1884, Dr. Ethridge was called to see the patient, whom he found in a pitiable condition. She was exsanguinated, feverish, and dyspeptic. She was placed on tonic treatment and rapidly convalesced. In October, 1885, she had an other hemorrhage, which lasted twenty-four hours before a sponge-tent was introduced. This tent was speedily forced out. Three more sponge-tents were subsequently introduced, and an enema of thirty ounces of fluid extract of ergot was given. Powerful uterine contractions ensued; the capsule of the tumor was ruptured, and the hemorrhage ceased. Three days after that one pound of the tumor was pulled and cut away. The tumor was pultaceous, friable, and accompanied by a disgusting odor. On the day following, one-half of a pound of the tumor was taken away, and two days later as much more. Three days later the patient was put under the treatment of ether, and Dr. Ethridge attempted to remove the remainder of the tumor, but only succeeded in removing two pounds more. After this operation, the patient went into collapse and nearly died. However, she recuperated so rapidly that in five days thereafter he removed another pound of the tumor. Five days later he succeeded in getting away another pound and the pedicle. The uterus, during the ten days past, had decreased rapidly in size, and the fetid vaginal discharge had lessened. During the three weeks in which the six pounds of gangrenous mass were removed, he expected the patient would develop sepsis, but none occurred. As the patient was continually under the influence of ergot, and shreds of the tumor came away between the times of the operations, it is safe to estimate the weight of the tumor at thirteen pounds. The points of interest in the case were, that the hemorrhages recurred most severely in the autumn, which was probably due to the changes in the circulation incident to the occurrence of cold weather; and also that, in order to remove these tumors expeditiously, it is imperative that we should be enabled to draw the tumor down into the vagina, where it can be grasped, and, at the same time, to continuously contract the uterus behind



the descending tumor so as to facilitate traction and to avoid hemorrhage.

The President remarked that this case teaches the lesson of the importance of early interference in fibrous tumors of the uterus, especially those that are large and accompanied by hemorrhages, which facts indicate that they are close to the mucous membrane, and under the effect of the contraction of the muscular fibres of the uterus, and thus susceptible to the influence of ergot.

Dr. Jacob Franks then detailed *A case of Vesical Calculus*, in which lithotrity was attempted. A Bigelow lithotrite was introduced, which grasped a stone measuring two inches. Upon turning the screw the instrument broke, and in consequence of this accident a portion of the instrument was left in the bladder. On the next day the lateral operation of lithotomy was performed, and the calculus and the broken piece of instrument removed. The patient made a good recovery.

The Society then adjourned.

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## PERISCOPE AND ABSTRACT.

### LOCATION AND TREATMENT OF RANULA.

Dr. E. Sonnenburg, in the *Archives fur Klinische Chirurgie*, xxix. 3 p. 627, treats the above subject. He relates the following case:

A six-year-old girl showed, in a widely-opened mouth, a tumor, which fluctuated and was of a bluish color. It was situated in the floor of the mouth, and was elastic to the touch. This pressed the tongue upwards, and made speech and the taking of nourishment quite impossible. Wharton's duct was on both sides of the tumor, free, visible, and readily sounded. The submental region was distended clear to the upper part of the thyroid cartilage. The extirpation was made through a six cm. long transverse incision in the region of the lower jaw. Still it was possible to free only the lower part of the cyst from the surrounding parts. On account of the great distension upwards, it was found necessary to evacuate the muco-purulent contents, and then through pulling forward of the cyst walls, which causes the tongue also to follow, but finally freed the cyst from the soft parts. By means of examination by the finger it was

found that the cyst was contained entirely in the substance of the tongue, and that only a thin shell of the muscles of the tongue was present. The bone substance of the lower maxilla was atrophic, and it projected past the superior maxillary three-fifths of an inch. On account of the falling back of the tongue, it was found necessary to draw this member forward with a thread. The wound, which was drained, healed in about fourteen days. The tongue appeared small, but in a normal condition, while the swallowing was good: but the speech was not yet distinct. The walls of the cyst showed a layer of epithelium. The contents consisted of mucus and pus cells.

The author has examined about fifty cases of ranula, and comes to the conclusion that they are in direct connection with the Blandin-Nuhn glands. There are two glands situated at the apex of the tongue beneath the mucous membrane, and the longitudinal muscular fibres formed by the styloglossus and longitudinalis inferior muscles.

In the operation the author recommends the following proceeding: One inserts a curved needle into the cyst-wall above and parallel with the duct of Wharton, fixes the cyst-walls by means of threads, which, if possible, also fix the tongue substance: then make a cut parallel with the duct of Wharton, and dissect the anterior wall, which one can draw out by means of the thread. Cauterization or drainage are then unnecessary. Quite large cysts are best extirpated *in toto* from the regio-submentalalis, which is not difficult.

In the author's fifty cases he observes no relapse.—*Med. and Surg. Reporter.*

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## A PECULIAR EFFECT OF CORROSIVE SUBLIMATE.

The bichloride of mercury is at present used a great deal for disinfecting purposes, and it is especially employed in large hospitals, where strict antisepsis is faithfully carried out. It has always been maintained that the drug, if diluted in the usual manner, caused no bad after-effects. Generally 1 in 1,000 is the solution applied to wounds, while 1 in 4,000 answers all antiseptic purposes. But that the first solution is not so innocuous as most seem to believe, is plainly proven by the following case:

Dr. J. C. Biddle, the well-known surgeon-in-chief of the State Hospital at Ashland, who is perhaps to-day, outside of Philadelphia, the most reliable authority in our State on injuries, treats all his numerous surgical cases on strictly aseptic principles. Last week he had a patient with a lacerated wound, extending from the upper part of the thigh to below the knee, and

connected with two large pus cavities. After these had been laid open, they were thoroughly washed out twice daily with a corrosive sublimate solution of 1 in 1,000. By the twelfth day, the thermometer showed an increase of 4 degrees above normal, which temperature soon became continuous. The patient besides suffered from a severe diarrhœa, which did not yield to any treatment. Finally, Dr. Biddle, on reflection, concluded that the symptoms, though greatly resembling septicæmia, were really caused by corrosive sublimate poisoning. He at once ordered the substitution of carbolic acid for the bichloride, with the result that within twenty-four hours the diarrhœa ceased, and the temperature became about normal. About the same time, Dr. Biddle made a similar observation in a milder case, so that there is no doubt of the casual relation between the drug and the morbid symptoms mentioned. As a contribution to the literature on the subject the facts quoted are decidedly of great interest.—*Med. and Surg. Reporter.*

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### LEUCOCYTHÆMIA,—LEUKÆMIA.

This disease, until recently, was regarded as a form of scrofula. In the year 1845, Dr. Hughes Bennett first called attention to the fact that cases characterized by great excess of white corpuscles in the blood, coupled with hypertrophy or hyperplasia of the spleen, and of the lymphatic glands in various parts of the body, was not ordinary anæmia, but a true leucocythæmia or leukæmia. About the same date Virchow described the same pathological condition, and called it leucæmia, or leukæmia, (meaning white blood). The name by Bennett, meaning white corpuscles, is the more appropriate.

This disease was never before this period differentiated from anæmia and scrofula, yet this peculiar condition had occurred in all civilized countries from the earliest medical history. Its diagnosis having been established by the use of the microscope. The name of this condition having been suggested by the altered condition of the blood only, is improper, inasmuch as the glands are as constantly altered from their normal state as is the blood. On this account Trousseau calls this disease adenie; Gresinger calls it anæmia splenica; Jaccoud calls it a lymphatic diathesis, and some writers call it anæmia lymphatica, medullo-splenic disease, etc.

CAUSES.—The etiology of this affection is quite obscure. It has been thought that mental and physical exercise to excess, coupled with bad ventilation, tends to the production of this disease, by impairing the general tone of the digestive organs.

**SYMPTOMS.**—One of the first indications of this disease is a state of great debility, variable appetite, impairment of digestion, disturbed sleep, nervousness, increased cardiac action from exercise, and paleness or an anæmic color. After some time, the spleen and lymphatic glands become very greatly enlarged. In a few months the patient complains of a great shortness of breath, palpitation of the heart, and a sense of fatigue from very slight exercise. About this time he, or she, may have febrile spells, with disorder of digestion, and perhaps diarrhœa, wandering pains in the head, back, limbs, with vertigo and dimness of vision. The urinary secretion is variable, being sometimes profuse, then again scant in quantity.

At this time, an examination of the heart's action will show soft blowing sounds over the base of this organ, with quiet pulse. In most cases the enlarged spleen causes fullness in the left hypochondriac region. And at this time the lymphatics are enlarged, especially over the groins and abdomen.

These symptoms rapidly intensify. The glandular swellings are from the size of a pea up to that of a hen's egg, and less hard than those of scrofula. The spleen increases in size, and sometimes fills the left side of the abdomen. In some cases the liver also becomes enlarged. The patient at this stage is liable to be troubled with diarrhœa, and sometimes more or less nausea and vomiting. Hemorrhage from the gums, kidneys, nostrils or bowels now takes place. Petechial spots appear on the body, and extravasations of blood may take place in the areolar tissue. And, in some cases, large extravasations of blood may take place upon the brain which prove fatal. Or death may result from dropsical effusions taking place in the areolar tissue, and in the serous cavities, but sometimes patients may linger for some time, then die from asthenia alone. Some cases prove fatal in five or six months, while others linger several years.

**POST MORTEM.**—One of the most important changes is that of the blood, which consists of an increase of the number of the white corpuscles, and a diminution of the red blood discs, so much so, that the red blood discs may not equal the white corpuscles. The blood is paler than natural. The urine may contain an excess of uric acid, traces of formic acid, and even lactic acid and hypoxanthin. And in some cases leucin, tyrosin and minute colorless octohedral crystals have been seen in the blood.

Great changes are found in the spleen, lymphatic glands, and the medulla or marrow of the bones. These changes consist of an increase of lymphoid cells and reticulated tissue and hypertrophy of the glandular structures, but the marrow of the bones is so inclosed as to prevent unnatural fatty matter, and is of a redish or creamy color. In some cases the lymphatic glands are



affected with hyperplasia, while the spleen is only slightly altered; these cases have been called lymphatic, leucocythæmia, etc.

**SPECIAL PATHOLOGY.**—The pathology is quite obscure, from the fact that we are comparatively ignorant of the physiological process by which the corpuscular elements of the blood are formed. It is understood that the white corpuscles are increased during the passage of chyle through the lymphatic glands, but just how and where the red corpuscles are elaborated is unknown. It was once supposed they were formed in the spleen. It is believed that the first step in the morbid process leading to pathological changes in this complicated disease, is the failure to complete the transformation of white into red corpuscles. This may consist in an imperfection in the composition of the said white corpuscles by which they fail to attract hæmoglobin. This failure of conversion of the white corpuscles into the red allows the white to rapidly accumulate in the blood, and in the adenoid tissues or reticulated tissues, causing hypertrophy of some part, as seen in the enlarged spleen and lymphatic glands. Inasmuch as the red corpuscles are not developed, and the existing ones slowly disappear, paleness, muscular weakness, shortness of breath, palpitation and general functional inaction result in this protean disease.

**DIAGNOSIS.**—Leucocythemia may be mistaken for other spanæmic conditions of the blood, or impairments of nutrition, such as chlorosis in girls, scrofula, pernicious anæmia, etc. But it may be distinguished from any of these affections by the increased number of the white corpuscles, and the diminution of the red, as seen on the field of a good microscope. Although the relative proportion of red and white corpuscles varies in different cases, but, in this disease the proportion may be said to be one white to twenty of the red corpuscles. But in health the relative proportion may be stated to be about one of the white to fifty, or even five hundred of the red corpuscles, according to the vigor of the assimilation.

It is believed to be necessarily fatal by old-school writers; but as the disease principally consists in a failure of the production of hæmoglobin, and its union with other constituents of the colored corpuscles, it is our duty to try to correct this diseased condition.

*Treatment.*—Prof. Nathan D. Davis, of the Chicago Medical College, recommends the following:

R.	Hydrargyri chloridi corrosivi,	1 gr.	
	Tincturæ cinchonæ comp.,	3 ozs.	
	Elixir simplicis,	1 oz.	M.

SIG.—Give 1 drachm in water before each meal.

No wonder the doctor should consider this disease incurable. Why prescribe the hydrargyri chloridi corrosivi in such a disease? In the first place, the corrosive sublimate is incompatible with the comp. tinct. of cinchonæ. (See *Bartholow's Materia Medica*, p. 220). On p. 230, the same author states that where a considerable quantity of mercury is administered, in a sufficient time it will affect the blood: the red globules are diminished in number, the fibrin loses its placticity, the proportion of water is increased, and various effete materials accumulate. And he says, "it interferes with the nutritive processes. A marked degree of anæmia, loss of flesh, muscular weakness, ulceration of the skin, loss of hair, eczema, diarrhœa, etc., are characteristic symptoms of mercury." H. C. Wood says, in his *Materia Medica*: "The blood suffers very decidedly; becoming more fluid than normal, and having its power of coagulation impaired." Dr. Wright found "that its solid constituents are notably diminished, including the albumen, fibrin, and the red corpuscles." But the outlook from a rational standpoint is more hopeful. The nitrum sulph. is a valuable remedy, (the sulphate of soda—Glabas salts), in doses of  $\frac{1}{4}$  to  $\frac{1}{2}$  grain, every three hours.

Thuja, O. C., in doses of one or two drops every three hours, is also a good remedy, especially after gonorrhœa. If the patient is very susceptible to cold, nux vomica, in doses of 3 to 5 drops of the saturated tincture will aid the cure. The nitrate of soda is also worth a trial, and where there is much water in the blood, the acetate of soda is indicated, and it may be alternated with the nitrate of potash. In some cases pulsatilla will do good service in doses of 5 drops every three hours. The patient should have a rich animal food. And in most cases the sulphate of sodium and the thuja will be sufficient to cure this obstinate disease.—*J. M. Goss, A.M.M.D., in Eastern Medical Journal.*

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## VERATRUM IN TYPHOID FEVER.

Almost every practicing physician knows the great and never failing effects of the fl. ex. veratr. vir. in all acute inflammations, where there is a full and bounding pulse, flushed face, etc., with high temperature; also a great many physicians prize it highly in the treatment of various forms of erysipelas, etc.

But I wish to speak of its effects in typhoid fever with a high temperature, a dry skin, sordes on teeth and a dry parched tongue, with pulse frequent and feeble. (Now I am aware that some one will say that something else would have succeeded better, and that the plan of treatment I shall here lay down, is not simon pure Eclecticism; but I care not what is said if my treat-

ment succeeds; it is when the treatment fails that criticism hurts.) In seven cases treated, I used the fl. ex. veratrum vir. in sufficiently large doses to hold the temperature down to 103 degrees, beginning its use as soon as the fever reached that point, and continued its use until the temperature in the morning came down to 98½ degrees, let that be two, three or even five weeks, giving it as follows:

R.	Fl. ex. veratr. vir.,	fl	3 dr.	
	Simple syr. squill,	fl	6 dr.	M.

Sig—Begin with nine drops every three hours, and increase one drop every dose until the fever is controlled and held below 104 degrees.

I have administered as high as twenty-one and twenty-two drops every three hours for a whole day and night. As soon as the least moisture appears on the skin, or the temperature starts down, I decrease the dose of veratrum at the rate of three drops at a dose. Of course I have a thermometer at the house, and have the temperature taken before each dose while giving the large doses.

Alternated with the above, I always give five to seven drops of turpentine (the oil) in mucilage of acacia every three hours. Also, a flannel cloth wrung out of a mixture of spirits turpentine and mutton lard, equal parts, is kept constantly on the bowels until the skin becomes reddened. Then this is left off a few days, and reapplied if tympanitis continues.

*Nourishment.*—Sweet milk, alone, generally is given just before or just after the turpentine emulsion, every three hours, with as much regularity as the veratrum, and as much as the patient will take, too—the more the better.

Never let a typhoid patient remain in one position too long, but have him turned—not turn himself—from one side to the other every three hours. This last refers only to patients who linger, and by lying too long on one side or the back causes congestion of the lungs.

In a practice of nearly five years in this county (Franklin), I have treated twenty-three cases of typhoid fever, with a loss of only one case—treated with quinine—and the plan above indicated is the one that has given the best results. Fever usually begins to decline about the fifteenth, or anyhow the twenty-first, day. In the above plan I have never been troubled with hemorrhage, strangury—as in cases where blisters were used—and very little trouble has arisen from diarrhœa. Patients sleep well generally, and make a rapid recovery.

One case treated as above indicated—except the local application—was a lady five and a half months pregnant, as she then declared, and as was after proven to be so by the birth of a

fine 10-pound boy at the time designated by the mother, whose fever on the morning of the sixteenth day was one full degree lower than the previous morning, and continued to decline at that rate until clear of fever, when recovery followed.

This is now the treatment that I pursue. Under it the weak pulse becomes strong, slow, and soft; the dry, rough skin becomes soft and pliant; in fact is all that could be desired; but understand, I am not an enthusiast, and should this treatment fail would not hesitate to try another. There are other conditions for which I use *veratrum*, of which I may say something sometime in the near future: provided, however, that this escapes the editor's waste basket.—*M. M. Hamlin, M. D., in Amer. Med. Journal.*

### DIAGNOSIS OF PREGNANCY.

Well, now this unmarried girl comes to us because she thinks she is pregnant, and hopes we can do something "to put it away."

"What makes you think you are pregnant?" Dr. G. asks.

"Because I have placed myself in a position to become so, and have not seen my courses for two months," the girl replies.

As a rule, we can not swear to pregnancy until we can hear the foetal heart-sounds; but there is fair presumptive evidence if the os is soft like one's lips. When the os is as hard as your nose, you may be reasonably sure that there is no pregnancy. Once in a long while a fibroid tumor will give us a soft os or cervix, but this is very exceptional. This condition we will find as early as the end of the first month, though it becomes more marked as pregnancy is further advanced. No matter what station in society a woman may occupy, no matter how exalted her position, when we find a soft os and cervix, we have a right to suspect pregnancy. Here there is a little softening, but very little. Her abdomen is too fat to circumscribe the womb and discover whether it is enlarged, so that evidence is here lost. There is only a shade of darkness about the nipple, not as much as there ought to be in pregnancy. This woman may not be pregnant, and may be suffering only from amenorrhœa. We will give her Bland's pill:

Dried sulph. of iron, carb. of potas., aa 3 dr.  
Glucose, q. s.

M. Ft. pill No. xlvijj.

SIG.—Two thrice daily for one week, and then increase one at each dose.

If she is not pregnant, this will bring on her menses, while if she is pregnant, it will not cause a miscarriage. Remember



that a natural abortion is not very dangerous: it may be likened to a ripened apple dropping from the bough. For some reason the ovum has become detached from the womb, and it passes harmlessly away. But if you pluck a green apple, you will tear also the bough or break the stem from the fruit; so when you produce abortion, you tear the ovum from its firm adhesions to the uterus and cause lesions that may result in septicæmia.—*Dr. Wm. Goodell in Med. and Surg. Reporter.*

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### RELATION OF LUPUS VULGARIS TO TUBERCULOSIS AND TREATMENT OF FORMER BY PARASITICIDES.

In the transactions of the American Dermatological Association, as reported in the *Western Medical Reporter*, we find the following reference to the paper of Dr. J. N. Hyde, of Chicago:

He began with a detailed statement of all the cases of lupus reported to the Statistical Committee of the American Dermatological Association during the last seven years, and compared the frequency of the disease in this country with that reported in the Vienna Hospitals. He then gave details of twenty consecutive cases observed by him in Chicago. The clinical deductions from these records were then added, showing, according to the author, that there was a remarkable absence of pulmonary tuberculosis, scrofula and allied diseases in the family histories of the last twenty cases reported.

The teachings of the two schools, represented in the past, by prominent German and French authors, were then referred to, and finally the latter investigations demonstrating that lupus vulgaris was the result of bacillus infection, not to be differentiated in external appearance from the parasite of the bacillus tuberculosis.

The following clinical facts were then cited in support of the later teachings on this subject, as bearing on the vital point in the author's argument, viz., that lupus vulgaris was not the result, as had long been taught, of tuberculosis or other systematic diathesis, but was the product of a local infection by bacilli, entirely unassociated with any constitutional evidence of diathesis or predisposition. 1. The unimpeachable character of the family record in by far the larger number of cases of lupus vulgaris. 2. The fact that the disease is in its inception a disorder of the period of childhood, when for the most part, the habits of the child are favorable to infection. 3. The several sites of predilection are those most favorable to such infection. 4. The

failure of the disease to spread by inheritance. 5. The remarkable tendency of lupus vulgaris to cutaneous limitation.

Dr. J. C. White, of Boston, read a paper on "the Treatment of Lupus by Parasitocides." He briefly interviewed the evidence in favor of the parasitic nature of the affection. All previous plans of treatment which had proven most successful, were those which would have the effect of destroying any parasite which might be present.

A number of cases were then reported in which the local use of corrosive sublimate in the strength of two grains to the ounce of water or unguent had been used with beneficial results. The ointment was especially recommended. It had been rarely necessary to prolong treatment over two months. As regards the permanency of the cure, the author was unable to speak, as the experiments had been continued for only eighteen months.

Dr. S. Sherwell, of Brooklyn, expressed his profound disbelief in the parasitic nature of the disease, and did not think that the theories of Koch had been entirely proven. It seemed to him that lupus and the scrofulous diathesis represent some form of syphilitic hereditary influence.

Dr. S. Wigglesworth, of Boston, suggested that the oleates might be more efficient than ointments, on account of their penetrating power.

Dr. Hyde said that at the last meeting of the Association, Dr. Taylor suggested the use of a solution of corrosive sublimate in tincture of benzoin. He had used this in cases of lupus and in cases of infecting chancre. It makes an excellent application.

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## CLINICAL NOTES ON "CHOREA LARYNGIS."— WITH CASE RECORD.

Laryngeal chorea, recognized as such, is of comparatively rare occurrence. It is within the limits of possibility, however, that a small percentage of all cases of spasmodic cough occurring in persons of neurotic habit is of a choreic nature, and that if the act of coughing were investigated laryngoscopically, more numerous instances of this affection would be recorded. An uncontrollable desire to cough, especially if of a barking character, when developed in a person the subject of chorea, should at once suggest its probable nature.

In forming an opinion, it is essential that the hysterical ele-

ment should be carefully excluded, a task not very easily accomplished, as one condition frequently coexists with the other.

A typical case of laryngeal chorea may be defined to be one in which there is an involuntary and uncontrollable cough during waking hours, absent during sleep, spasmodic in character and accompanied by various sounds resembling the noise produced when straining, the barking of a dog, and so forth. There is associated with it spasm of the expiratory muscles of the chest and abdomen. The speaking voice is normal, articulation is perfect, and the general health usually good.

On laryngoscopic examination, which is generally well borne, the act of coughing is found to be preceded by spasm of the laryngeal adductor muscles bringing the vocal cords into close relation, often with an audible click, when the action of the expiratory muscles suddenly forces them apart, producing the somewhat characteristic cough. Between the acts of coughing the glottis assumes a variety of shapes, constantly changing its outline, indicating choreic movements of the intrinsic laryngeal muscles. The larynx itself presents but slight departure from a state of health, if we except trifling congestion of its mucous membrane, and occasionally, perhaps, a moderate degree of swelling.

Under the designation of chorea laryngis a number of cases have been improperly described, as, for example, those in which the expiratory muscles of the abdomen, or of the chest and abdomen, have alone been affected, producing a spasmodic cough, it is true, but in which no laryngeal evidence of chorea was obtainable. Strictly speaking, the term should be confined to those in which we find by direct inspection motor implication of the intrinsic muscles of the larynx, whether accompanied by spasm of the muscles of expiration or not. In other words, the diagnosis of chorea of the larynx should depend upon recognized choreic movements of the laryngeal muscles, and the existence of a general chorea preceding, accompanying or following the laryngeal motor neurosis should strengthen and fortify rather than detract from the accuracy of our diagnosis. In the absence of spasm of the expiratory muscles, one must be prepared to make a diagnosis without the assistance of cough as a symptom. Such cases are, however, exceedingly rare, as the whole range of medical literature furnishes but one (Knight's) solitary instance.

For the better illustration of this uncommon neurosis there is appended a short clinical report of a case which recently came under observation, a perusal of which may be found interesting:

Mlle. R., a healthy-looking young lady of sixteen, was seen in consultation with her medical attendant, Dr. Proulx, on Octo-

ber 27, 1885. She was suffering from a cough of a barking character, which was not only a source of discomfort to herself but of great annoyance to her family. The cough, which had already lasted two months, occurred at regular intervals of three or four minutes and was entirely absent during sleep. All the ordinary remedies, local and constitutional, had already been resorted to without perceptible improvement. On critical observation the cough was found to be explosive as well as barking, and was followed by a decidedly laryngeal sound resembling that of œdematous laryngitis. The young lady complained of some slight distress of breathing when recumbent. All attempts on the part of the patient to control the cough were unavailing. Articulation was perfect, and at the time of the consultation there was an absence of symptoms of hysteria, general chorea, or other nervous affections.

On making an examination of the larynx—a matter, by the way, of easy accomplishment—moderate congestion of the lining mucous membrane, especially in the neighborhood of the arytenoid cartilages, was found. The vocal cords, though not of normal pearly lustre, were not hyperæmic.

The act of coughing was observed with the mirror, and presented the following features: The vocal cords were first thrown into violent contact, and after so remaining for a few seconds were as abruptly forced apart, when the cough took place. During the act, the spasm of the adductors never thoroughly relaxed, but varied in degree. The laryngeal sound which followed closely in the wake of the first respiratory effort may thus be accounted for. Spasmodic action of the abdominal expiratory muscles coexisted. In the intervals between the acts of coughing the glottic space presented a varied configuration, without, however, in any way interfering with the function of healthy respiration. Throughout this kaleidoscopic period of glottic images there predominated in a marked degree the well-known outline of double thyro-arytenoid paralysis, with paresis of the arytenoides. This latter condition may have had no direct connection with the neurosis, and probably had not, but was more likely a secondary result of continued strain and fatigue, extending over a long period of unnatural activity.

Laryngeal chorea was diagnosed. On expressing this opinion, Dr. Proulx cordially endorsed it, and in support of it stated that preceding the stage of cough there had existed a well defined more or less general chorea, which necessitated the withdrawal of the young lady from the convent school in which she was a pupil.

On December 4th, in reply to a letter of inquiry concerning the progress of the case, the doctor reported decided improve-



ment under the use of liquor arsenicalis, supplemented occasionally by valerianate zinc. There had been a gain in weight and an improvement in appetite. The cough also showed decided amelioration. Altogether, he considered the patient as speedily convalescing.

Laryngeal sprays of cocaine did not afford any relief—as good an argument in favor of the neurosis of motion theory of chorea laryngis as it is against the theory of reflex action from laryngeal hyperæstheia.

The foregoing clinical history is most instructive, as it groups in a very complete manner the characteristic, though not always constant, features of chorea of the larynx—a condition the recognition of which is extremely important, as it may exist independently of any other chronic symptom. The treatment of this disease must be carried out on the general principles found useful in controlling chorea in other organs. Works on general medicine do not treat of this local manifestation of chorea, nor, indeed, do the authors of standard publications on diseases of the nose and throat. For information on this obscure phenomenon we are dependent upon rather less than a score of articles (the majority of which are case reports) that have appeared from time to time in the medical journals.

Five investigators only have recorded their observations in our language.—*Canada Med. and Surg. Journal*.

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### AMMONIA-POISONING.

On Friday, P. M., November 27, 1885, my little son two years old, came running to me in my office adjoining my sitting-room, and crying, stuck his finger into his month, at the same time making ineffectual attempts to vomit, during which he spat out considerable mucous, which I noticed was tinged with blood. Believing he had swallowed some irritating substance, I at once forced him to drink considerable warm water, followed by syrup of ipecac. While administering these I accidentally got the fumes of ammonia from the clothing, and at once saw the serious nature of the case. In twenty or thirty minutes after taking the ipecac copious vomiting occurred, once only. In about five minutes after vomiting he began to have great difficulty of breathing, which increased so rapidly that in less than three minutes I thought the child moribund.

The difficulty of breathing I at first thought to be caused by a spasmodic croup, but further observation satisfied me that it was an œdema of the glottis. His breathing was as difficult as in the worst case of membranous croup I ever saw, and of

course identical in kind, being caused by an obstruction in the trachea. I at once sent for counsel. Three physicians arrived in about ten minutes, by which time his breathing was slightly easier. They all advised steaming with lime-water to relieve the irritation of the tracheal mucous membrane. While under a blanket with the child I noticed that his pulse suddenly became weak and intermittant. We immediately gave stimulants per rectum, brandy, one grain of quinine, one or two drops of tinct. *nux vomica*, and, later, *digitalis*. The force and rate of the pulse was reduced very much, and it was very irregular, beating three or four beats in rapid succession and then skipping two or even three beats. Sinking attacks developed, in one of which the ordinary tracheal rales that accompany death were very loud, and the child became very livid. He rallied, however, only in the course of half an hour to pass into another similar but milder attack. Death seemed imminent several times, but I believe it to have been averted by the stimulants injected into the rectum, and hypodermically.

The breathing continued difficult until I obtained a steam atomizer in which I used a mixture of glycerin and lime-water, which seemed to relieve very promptly. From the fact that no symptoms of pain in the bowels were manifested and that there was neither vomiting nor purging, we concluded the child had not swallowed any of the ammonia, but the caustic action of the alkali was plainly visible on lips, tongue, and even fauces: there was difficult deglutition for forty-eight hours. Of course it was the fumes of ammonia only that reached the tracheal mucous membrane. I should be pleased to have the opinion of the readers of the *Age*, who have had similar cases, as to proper management of cases of this kind. What caused the heart-failure at least forty-five minutes after the inhalation of the gas occurred? I am well aware that over-stimulation induces paralysis, but it seems to me that it ought to follow more promptly, or not at all.—*Medical Age*.

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## DIFFERENT FORMS OF PARALYSIS MET WITH IN YOUNG CHILDREN.

The following abstract of a paper by Dr. Wharton Sinkler, read before the Obstetric Society of Philadelphia, is found in the *Obstetric Gazette* for December, 1885:

The most frequently met form is infantile spinal paralysis or *poliomyelitis anterior*. This term indicates the pathology of the disease, which is an inflammation of the nerve cells of the anterior horns of the white matter of the spinal cord. This affec-

tion may come on at any period in life, but is generally seen in children, and usually at the age of ten years. The children are generally strong and apparently healthy, and the paralysis is sudden in its onset. Fully two-thirds of the cases I have seen have been attacked in the summer months, hot weather and teething seeming to be predisposing agents. Dr. Barton, of Manchester, Eng., reports that of fifty-three cases in which he noted the time of onset, twenty-seven occurred during the months of July and August. The attack is preceded by fever of greater or less intensity, with pain in the head and limbs, and with general soreness when moved or lifted. After a few days paralysis more or less complete occurs, but in a few days a regression of the paralysis from some of the afflicted parts occurs. Sensation is undisturbed. Atrophy of the muscles is soon apparent, in fact, the paralyzed portion stops growing for a time. The temperature of the affected portion is low and the skin is blue and mottled, but there is no tendency to ulceration, and wounds or scratches heal readily. The skin and tendon reflexes are lowered or abolished in the affected limbs. At first response to the faradic current is lost, but later on the galvanic current produces but little muscular contraction, except when a powerful current is used.

When atrophy has set in the reaction of degeneration is seen. Most of the cases of club-foot are the result of infantile palsy. Deformities of the upper extremities are rare, this disease differing in this respect from cerebral palsies.

The exact causes of infantile palsy are unknown. Over-fatigue often precedes an attack: sudden chilling is considered by Séguin to be a frequent cause.

The prognosis as to perfect recovery is only moderately good. In many cases the most faithful treatment fails to relieve the paralyzed muscles, but in almost every case we can expect more or less improvement.

In the early stages of the paralysis, after the subsidence of the fever, the treatment should consist of mild stimulation of the spine: ergot and small doses of bromide of potassium should be given internally. Later in the disease iodide of potassium should be given instead of the bromide. When the palsy is established, electricity and massage are the means to be depended upon. They must be persisted in for months, or even years. Internal treatment is of little or no value unless there is some failure in the general health of the child.

*Spasmodic Paralysis*, as seen in children, is of two varieties. When of primary spinal origin, or when there is a descending degeneration of the cord from a primary cerebral lesion. Sometimes there seems to be a congenital defect in the motor tract of

both brain and cord. In the spinal variety there is often seen, soon after birth, rigidity of the limbs: at first this is only occasional, but as the child gets older every effort to move a limb causes muscular rigidity in it. The child does not attempt to walk until three or four years of age. Then, when it is supported under the arms and tries to stand or to walk, the movements are very peculiar and characteristic. The feet are extended and inverted, so that the child rests on the toes. The knees are strongly adducted and lock together, so that the legs become entangled. By degrees the child becomes able to walk by the aid of apparatus or some form of crutch. The hands and arms are often affected, and every effort causes muscular rigidity to come on. The mind is unaffected in these cases, and the speech may be distinct, although it is often very defective. Sensation is unimpaired, and the patella reflex and ankle clonus are exaggerated. There is no wasting of the muscles.

By these symptoms we infer that the disease is localized in the lateral columns, but exactly what is the nature of the lesion we do not know, for no post mortem examinations have been made in these cases. The cause is unknown. Hamilton found three of seven cases which he had collected were premature births: adherent and contracted prepulse has been thought by some to be caused by reflex influence of the spasmodic paralysis, but operation has not given relief.

The treatment should consist of massage, galvanism of the spine, ergot and cod-liver oil. Fluid extract of conium may be given to allay spasm. In some cases great improvement follows this treatment.

Even where we can do no particular good to the limbs, very much can be effected by the aid of apparatus. Properly adjusted braces to the legs will enable a child to walk on crutches or in a Darroch wheel crutch.

There is a form of spasmodic spinal paralysis in which the child is imbecile. In these cases there has probably been congenital defect in the cerebral development. The head is small and there is no evidence of intellect. Often mystogeneses is present.

*Paralysis from Potts' Disease.*—Paralysis of the lower extremities may result from caries of the spine. The lesion may be either a meningitis or a myelitis. If meningitis alone, there is considerable pain and contraction of the legs. Generally there is a transverse myelitis. The symptoms are numbness and pricking of the legs, with loss of sensation: gradual increasing loss of power, with wasting of the muscles: incontinence of feces with retention or incontinence of urine. Sometimes there are ulcers over the sacrum or on the limbs.



The indications for treatment are evident. An apparatus which will take the weight of the body from the spine is necessary, and is sometimes sufficient of itself. Frequently, however, the employment of the actual cautery over the spine brings improvement in the symptoms when an apparatus has done no good. Massage and electricity should be used to restore the atrophied muscles.

*Paralysis from Rachitis and Diphtheria* is seldom complete. The former is often spoken of as the pseudo-paralysis of rickets. Negro children, who are very subject to rachitis in cities, often have richitic paralysis. The child at three or four years, is unable to walk or stand. Sometimes it has not sufficient muscular development to sit upright. It can move every limb and has no loss of sensation, but has no power. Cod liver oil and massage bring about the most satisfactory results in these cases.

*Diphtheritic Paralysis* usually begins in the muscles of the soft palate and pharynx, and extends to the extremities. It is generally bilateral and incomplete, but I have seen a case in which it was hemiplegic. It is considered peripheral in character, and is believed by some to be connected with the altered condition of the blood consequent upon the original attack.

Diphtheritic paralysis is rarely fatal, and lasts in most cases only a few weeks, although it may continue for months. Strychnia and electricity are the means to be employed, and the case usually responds promptly to these remedies.

*Pseudo-hypertrophic Paralysis* is a rare affection, but is of much interest. The disease belongs almost exclusively to infancy. It is characterized by muscular paralysis with great increase in the bulk of the muscles. This enlargement is due to fatty deposits while the muscular tissue proper is atrophied. The affection begins with weakness of the legs, a peculiar balancing of the trunk, and separation of the legs in walking. There is great difficulty in getting from a sitting to a standing position. Later in the disease the muscles become wasted and shrunken and the general health begins to suffer. Death results from implication of the respiratory muscles.

The skin is mottled like a piece of castile soap. The tendon reflexes are abolished and electro-muscular contractility is impaired. There is often a greater or less amount of mental weakness. There is no loss of power over the bladder and rectum, and sensation is not affected. Heredity influences the disease, which is slow in its progress, but the course is steadily downward.

*Frederick's Disease* is still more rare than the preceeding. It is practically locomotor ataxia in childhood. Here is evidenced

also a hereditary disposition, and the female children seem most liable.

*Cerebral Palsies.*—Hemiplegic may result from some injury at the time of birth, either from the forceps or from the pressure of a prolonged labor. A child may be born hemiplegic after a perfectly natural and easy labor. Under these circumstances we must regard the paralysis as the result of imperfect cerebral development. Hemiplegic under these circumstances is generally permanent. The side affected grows less rapidly than the other. The flexors of the arm and hand are usually contracted. The leg becomes rigid in the act of walking.

Convulsion is most always associated with cerebral paralysis, either immediately preceeding the attack or occurring soon after. The convulsive movements are most violent on the side which is subsequently paralyzed. The child will have an idiotic expression and speak indistinctly, but their friends think them intelligent.

The convulsions are liable to return when the child is older, and then assume an epileptic form. The walk is peculiar and is called the *spastic* gait. The patient plods along looking as if he were about to pitch forward. The affected limbs are smaller and shorter, the growth of both bone and muscle being affected. In the choreic variety, where the arm is in constant motion, the muscles may become hypertrophied, but the bone remains short.

Prognosis.—As a rule, the prospect of recovery is bad, even if the patient gets well the hemiplegic side remains awkward.

Treatment.—Cod liver oil and massage, which always relaxes the contracted muscles. The affected limbs should be used as much as possible.

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## A GUNSHOT WOUND OF THE LUMBAR VERTEBRÆ, WITH RECOVERY.

It is not so long since the occurrence of a case where the possibility of recovery after a gunshot wound of the lumbar vertebræ was discussed as a matter of international interest, that the subject has been forgotten. A renowned foreign surgeon—Esmarch—was by many taken seriously to task for uttering the belief that in this particular case the wound was not of necessity fatal, although he showed that similar wounds in many of the lower animals were recovered from. Recently a case has been reported by Albers (*Deutsch. Militärzch. Zeitschft.*), which must forever settle this question. It is, in other words, the first case of the kind recorded in surgical literature.

A man received a bullet wound during a duel, the ball, of large size, entering two centimeters above the right iliac crest. Hemorrhage was immediate and profuse. Thick wads of salicylic cotton were tightly bound on, and the bleeding thus checked. On the instant of reception of the wound, the man fell, half fainting, and motionless below the waist. He was carried nearly a mile to a conveyance, and then as much farther to a hospital. There ice was applied to the abdomen and morphine administered on account of pain. The next day he had a sharp attack of peritonitis, and urine was suppressed. After the sixth day, the peritoneal inflammation subsided, and now, on dressing the wound, it was found that a little pus escaped. Now, for the first time, the probe was used, and passed easily to third lumbar vertebra, where at a depth of three centimeters the ball was felt. On withdrawing the probe it met with an elastic resistance. It was therefore determined by the findings with the probe and by the general features of the case, that the bullet had passed between the coils of intestine, had pierced the third lumbar vertebra, entering the spinal canal between the bone and the cord, had passed out of the bone and lodged in the soft tissues beyond. No effort was made to remove the ball: only a drainage tube was introduced.

This diagnosis was verified by return of power to urinate, and very gradual return of mobility in the lower extremities, though only after months was the patient able to walk with a cane. Perfect recovery was only attained after three years and a half.

In view of the results thus gained, Dr. Albers emphasizes the necessity for special care as to the following points, when dealing with shot wounds of the spine:

1. Immediate hæmostasis for the preservation of life.
2. Transportation to the hospital soon as possible.
3. Prompt antiseptic occlusion with change of dressing as often as every day, if necessary. He prefers salicylic cotton.
4. Probing *only* in case there be suppuration, and then with a thick knobbed sound.
5. This probing should be most cautiously done, and should at the same time open up a path for drainage.
6. Isolation from other surgical or fever cases, with rigid precautions against bed sores.
7. The removal of the ball may be generally left to the extrusive effect of granulations, which may remove by degrees a heavy piece of lead.
8. Recovery from paralysis due to contusion of the cord is possible, even after a year.—*Medical Press.*

## A CURIOUS MISTAKE.

The following anecdote is related as an actual occurrence: A young man fresh from college, whence he came with honors and medals, was sent by his father, a practitioner of fifty years' standing, to attend a woman in labor. On making a digital examination, he found the os uteri undilated. After waiting an hour, there being no improvement, he applied belladonna ointment, and endeavored to make forcible dilatation. At the end of another hour there was still no dilatation; and being alarmed, he sent to his father for assistance, but before they returned the child was born. On examination, the father found that the child's anus was red and patulous, and was liberally besmeared with belladonna ointment. The young practitioner had met with breech presentation, and had mistaken the child's anus for an undilated os uteri.—*Obstetric Gazette*.

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## ENURESIS NOCTURNA AND NASAL OBSTRUCTION.

That enuresis nocturna is frequently associated with impediment and obstruction to free breathing through the nose has been claimed by Major, a Canadian physician. Dr. Zeim, of Danzig, corroborates this in the *Allgem. Medical Centralzeitung*.

Appropriate local treatment of the nasal cavities is said to lead to relief and cure of the enuresis.

This is a practical suggestion that certainly merits our attention.

The connection between the two troubles and the causal relationship to the enuresis is sought in the relative respiratory deficiency, and consequent carbonic acid intoxication, that follows in individuals that breathe through the mouth.—*Medical Review*.

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## "PROFESSIONAL."

In view of the fact that an esteemed contemporary once got itself into hot water because of its reference to the pap-sucking habit of certain Texas mothers, we ought not, perhaps, to publish the following report of a cannibalistic performance by two Texas doctors: "Dr. Palmer, who, in a fight with Dr. Calloway, at Bloomington Grove, had the end of his finger bitten off by the latter, is in a critical condition, owing to blood-poisoning having set in." Inasmuch, however, as the quotation is from the *Texas Courier-Record of Medicine*, we presume the report is not libelous. Nothing is said of the effect of the toothsome morsel on Dr. Calloway, and it is presumed it did not contain enough ptomaines to disturb his stomach.—*Medical Age*.



# THE PEORIA MEDICAL MONTHLY.

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## EDITORIAL.

### SOCIETY WORK.

It may be that

“A little nonsense now and then  
Is relished by the best of men,”

but for men of at least ordinary intelligence, it will not answer as a steady diet. The mental digestion of the average doctor is sufficiently good to chylify a moderate amount of solid food, and he *must* have it. Societies are, in many respects, like individuals. They are weakly or robust, in proportion to the character of the *regimen* to which they are subjected. That which is profitable to a *part* is profitable to the *whole*; that which is profitable to the individual, is profitable to the association. Community of interest is the cohesive attraction of societies. Feed the individual, and you feed the society; furnish that which is of interest and profit to the individual, and you furnish that which is of value to the society.

Medical associations are no exception to the general rule. All are convinced of the desirability, not to say necessity, of professional organization. As individuals, we owe something to our profession and our professional brethren; the question is, *how can we best compass the payment of our debt?* It is one of vital importance to the welfare of any medical organization, and the practical answer to it will put upon such organization the seal either

of success or failure. The debt which we owe to our professional brethren, our profession and ourselves, is an honest, earnest effort to widen the boundaries of medical science and art. In a *union* of effort there is strength. Each individual views a matter in a different light from any other. Every man sees from a different standpoint from any other; but the aggregate of views tones down the colors of misconception, and presents a picture approximately perfect.

The true principle of society work must embody a recognition of the truth of the foregoing.

Eschewing all reference to the purely common business routine of medical society organization, the writer confesses to an opinion that, in the first place, in societies of this kind, more time than is desirable is consumed in the formal and, strictly speaking, *scientific* work of the evening, and not enough, if any, devoted to an informal, and more strictly social intercourse between members. Dignified, honest, sincere social communication, involving an informal discussion of matters of mutual interest, and the consequent suggestion of material for serious and combined consideration, is one of those features which ought not to be overlooked in constructing a plan for attractive and efficient medical society work. It should be the duty of every society of physicians to work for and foster a disposition to throw aside the selfishness which proverbially characterizes the profession, and encourage the informal consideration of matters pertaining to the ethical and other spheres of medical experience not usually considered matters of scientific importance.

In the next place, and as to the work proper of an association having for its object the discovery and development of scientific truth in its relation to medicine, it is but fair to assume that nothing of an unimportant character should be presented for consideration. That and only that which is new or rare, original in fact, thought or description, should be offered for the hearing of reading, thinking men.

It has been argued here that general practitioners, who necessarily make up the bulk of attendance at societies, who occupy the tread-mill of daily professional work, and whose duties and observations are confined to the limits of private practice, cannot be expected to advance much that is new to the science

and art of medicine and surgery. Certainly such argument is fallacious. While it will be readily admitted that where special laboratory conveniences, and the like, are required, the physician connected with an institution guaranteeing these necessary conditions has an advantage, it is equally certain that for many other purposes of equal importance he is not so happily situated. Every man has opportunities in his own sphere of action, which are presented in no other; and it is the product of these that in society work we want to draw out. If a paper is to be presented on any subject, let it not consist of a reiteration of theories or facts from well-known authors, whose ideas can be gleaned from their own pages in the quiet and comfort of one's own library; let it not cover so much ground, so to speak, as to render its discussion, in anything like fullness, utterly impossible in the limits of one meeting. On the contrary, if a paper is presented on any subject let the latter be so small a fraction of another, or innately so limited in extent, that the treatise shall be necessarily brief. Curtail it so that it *must* hug the confines of the generally unknown as closely as the ability of the author will admit, that those who listen to and discuss it will be compelled to concentrate the lances of their intellects upon its obdurate mysteries, in order to make an impression. *Concentration of thought* is what counts. Its *processes* always *interest*, its *methods* always *delight*, and its *results* always *instruct*.

If the clinical history of a case is to be presented for consideration, let it be characterized by brevity, by the greatest degree of accuracy in every detail, including a systematic examination of the various organs, fluids and secretions, together with a clear and accurate description of the remedial measures resorted to, in their order, coupled, in case of death, with an accurate and painstaking autopsy. Such, and only such a degree of accuracy will suffice to profit the observer himself or his confreres, and admit of scientific discussion. There must be an absence of that element of doubt in regard to "knowable" points, which so often destroys all value of and drives away interest in such reports. Nothing short of these characteristics will suffice for either interest or argument, and nothing short of a determination to present all that is ascertainable should admit of one's assuming the task. *Any* earnest man, no matter in what walk of professional life, can do

so profitably if he only *will*. It is not that he does not have opportunities, but that he does not embrace them. Physicians generally are, undoubtedly, too liable to under-estimate their opportunities. Many of the theories which have stood the test of time and criticism have been originated and promulgated by men in the more lowly walks of professional life. Men—observant men—whose relationship with certain classes, sections or other influences peculiarly fitted them for the work which they accomplished. Many of the names which adorn the brightest pages of the history of the progress of our art, belong to those who originated and developed practical efficiency in the walks of private practice and the quiet of their unhindered perseverance.

To epitomize: Every one of us has observed, thought of, stumbled over, had thrust upon him, or in some way been made aware of something rare, if not altogether new which it is our duty to present to the consideration of our colleagues in one form or another. No man having regard for the value of time wants to fritter it away. Therefore let our communications be brief and to the point. Narrow the subject so that the thought involved in its discussion may gain impetus and force its necessary concentration. The more nearly exhausted a subject the more interesting its discussion becomes, and like the wringing of water from a sponge the more drops of fact one can squeeze out of it then, the more credit is his due and the greater our stock of knowledge concerning it. Let the subject be so “cornered” that it cannot get away from us nor we from it.

Let it be known sufficiently in advance what this subject for discussion is, that all may be prepared, and, above all, let us have that *accuracy of description, which alone can form the basis of intelligent and logical deduction.*

O. B. W.

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### CURE FOR HYDROPHOBIA.

An exchange gives the following, apropos of the present popular and professional manifestation, of interest in the above subject:

The old recipe of “a hair of the dog that bit you” was almost literally realized in a prescription for the cure of hydrophobia much in vogue with the Pasteurs of the fifteenth century.



"Take a mastiff pup of a month old and stuff the same with cloves, cinnamon, and divers other spices, and thereafter boil the carcass entire, the which, taken warm from the pot and laid into the part that had been bitted, will, without doubt, do much good"—which, somehow or other, it did not. A more primitive but more successful method was employed within the memory of living men in a remote part of Ireland, the patient being the eldest son of the family, a fine lad of nineteen. His recovery appearing hopeless from the strong symptoms of hydrophobia which he exhibited, the doctors decided upon bleeding him to death as the only alternative to the barbarous plan of smothering under a feather bed, which was then common. A vein was opened, and he was locked into an outhouse and left to die. But toward evening, the milkmaid of the household, passing near the spot with her pail, was amazed to hear the sufferer's voice faintly asking for "something to drink." Overjoyed at this unmistakable sign of recovery, she lost no time in summoning assistance, and the young man's life was saved, the physicians ascribing his extraordinary escape to the carrying off of the poison by the copious flow of blood.

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### RAPID BLISTERING.

A blister may be rapidly drawn as follows: A few drops of aqua ammonia, concentrated, should be placed in a shallow cup and covered with a pledget of cotton. The cup must then be quickly inverted and pressed firmly and closely to the part to be blistered. The desired result will be obtained in twenty minutes.—*Kansas City Medical Index.*

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### NIGHT SWEATS.

In night sweats of phthisis in which quinine, atropine, ergot, etc., fail, hypodermic injections of picrotoxine ( $\frac{1}{30}$  to  $\frac{1}{65}$  of a grain gradually increased) will be found to afford relief. It may also be administered by mouth.—*Ibid.*

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### NITROGLYCERINE vs. ALCOHOL.

Says a recent writer: "Nitroglycerine will readily replace alcohol wherever and whenever this latter might be used as a

cardiac and cerebral stimulant. One drop of the one-per-cent. solution is more than the equal of one ounce of brandy in such a case."

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### A LITERARY GEM.

Under the above caption the *Kansas City Medical Index* for December contains the following:

We are just in receipt of the following letter from a man signing "M.D." to his name, and engaged in the practice of medicine in Illinois:

"Hav Red of your Valable Jornel In my surg Rep of Pa and six other Med Jornels But hav never had the Opportunity of seeing a Copy Wold Be Pleased to Receive a sampel copy."

Fortunately *The Index* has no subscribers of this class. even if "six other Med Jornels" have.

We presume the above is intended as a covert commentary on the inefficiency of the Illinois State "medical Practice Act," and as such is not entirely out of place, but we venture to assert that the "M.D." above referred to is practicing in this state by the "grace of God" and the ten year exemption clause of the above mentioned act.

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### WEAKENING OUR NATIONAL ENERGY.

Under the above heading the *St. Louis Globe-Democrat* make the following very timely observation:

There is hardly a house among the well-to-do classes that does not contain its bottle of morphine or some similar "medicine," so called, which is administered upon the slightest occasion and with very little, if any, consideration of its well-established evil qualities and tendencies. Thousands upon thousands of otherwise sensible and discreet men and women turn to such remedies in cases of passing headache or sleeplessness, and even the little ailments of children are frequently so treated by thoughtless parents.

It is impossible to doubt that in time such a practice must materially diminish the country's fund of general energy, and correspondingly reduce the measure of its conquest and progress. We can not hope by any improvement of opportunities to maintain our standing for enterprise and the accomplishment of great and far-reaching objects if we forfeit the strength which has so far enabled us to win in spite of all obstructions.

## A SUBSTITUTE FOR IODOFORM.

To the progress of synthetical chemistry we owe an addition to our present list of antiseptics which, if on further trial it be found to bear out the promises made for it by its discoverers, bids fair to take the place of iodoform altogether. Iodol, the substitute referred to, is a dark powder obtained from "Dipple's animal oil." It has but little smell, and is soluble in 3 parts of absolute alcohol, but only in 500 parts of water. More than two hundred observations on various diseases have been made with it in the Royal Surgical Institute in Rome. It was used in substance, suspended in glycerin, dissolved in alcohol with glycerin, and as ointment. Chancres were washed with distilled water, very carefully dried, and sprinkled with iodol in powder, and covered with silk protective, the dressing being changed daily. In six days' time the base of the chancres began to granulate, and the edges to show signs of commencing cicatrization. Similar treatment was adopted in the case of open buboes, which very soon began to exhibit a healthy appearance, and in a short time healed up. In many cases of simple indolent ulcers iodol was equally valuable, the whole character of the sore becoming changed after a few applications. Neither erysipelas nor diphtheritis was ever observed in cases treated with iodol.—*London Lancet*.

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## NOTES AND COMMENTS.

It was the misfortune of Mrs. Maggie Ryan, of New York City, to meet with an accident, which rendered the amputation of one of her legs necessary. Now Mrs. Ryan thought a good deal of that leg, even after it had been divorced from her body, and insisted that it should be given Christian burial in her plat in the cemetery. The doctor was somewhat puzzled to know what to do under the circumstances as he was not sure Mrs. leg had a soul, but finally on consulting with the coroner he prepared a death certificate that he believed would pass muster with the board of health and it did. The document set forth that Mrs. Ryan's leg died of amputation in the Chamber Street Hospital on November 29, 1885, that it was fifty years old, married, and part mother of a family. The leg was then placed in a very narrow coffin and buried with all due ceremony.

We learn from the *Journal of Obstetrics* that Dr. Henry J. Garrigeus, of New York, has just been elected Gynecologist to

the German Hospital, of that city, vice Dr. E. Noeggerath resigned. From the same source we learn that Dr. P. F. Munde has been elected a Fellow of the British Gynecological Society. In this connection, although far removed from the "seat of war," so to speak, we desire to say that from our personal knowledge the above mentioned gentlemen will do honor to the positions to which they have been severally appointed, and we are glad to know that their merits are receiving the notice to which they are entitled.

NEW DISEASES OF THE NERVES.—Cosmophobia, or "dread of the world process," has rescued from its metaphysical exclusiveness, and is to be studied as a nervous disease. A patient suffering from it is described by Dr. Vance in the *Medical Review* as believing that "the power of the world is a power of evil, and existence a frenzied carnival." He is troubled with "irritability of that part of the physical mechanism concerned in the elaboration of the intellectuo-emotional ideas," and is generally out of joint with the world, temperamental predisposition being a prime factor in the trouble.—*Medical Journal*.

Certain appalling statements were recently made by a physician to a medical class in Buffalo, N. Y. He announced that one-fifth of all mankind die of consumption alone, and one-third of all from the ravages of tubercles upon the bodily organs, including the lungs. Comparing this mortality with that from yellow fever during the epidemic of 1878, he said that it "would require 450 years of such epidemics of yellow fever to equal the devastation wrought by consumption in a single generation in this country alone, and 750 years of such work to equal the mortality caused by tubercles in one generation in this country."

Dr. Quain, an eminent London physician, remarked in the course of his recent "Harveian oration," that fifty years ago a patient could command no anæsthetic to induce insensibility to pain, no antiseptic to promote the healing of a wound, no chloral to procure sleep, no antipyretic in general use to control fever. He showed that in the past forty-five years the mean duration of male life in England and Wales has been increased by two years, and that of women by three and a half, the greater portion of such increase being subsequent to childhood and prior to decrepitude.



Some men are natural jokers and cannot resist the impulse even in the jaws of death. Curran's physician remarked to him when he was on his death-bed that he seemed to cough with more difficulty. "That is surprising," returned the wit, "as I have been practicing all night." A local celebrity when on his death-bed in this city, was informed that it had been decided to tap him for the ascites from which he suffered. "Then it's all over with me," he replied. "Nothing has ever lasted long in this house after being tapped."—*Med. Age*.

"No," said the doctor, boastingly, "I never make an autopsy of the body of a patient of mine. It is not necessary. A physician who makes an autopsy tacitly confesses to ignorance of his profession. He says to the world: 'I do not know what killed my patient. I am going to see.' I do not need to do that. I know what kills my patients."

"And so does everybody else who knows that you attend 'em," remarked a bystander. And the doctor strode away with a very red face.

The *Philadelphia Ledger* thinks that the regulation of the diet is the principal field for advance in the medical profession in the near future. It is evident, even to the surface observer that foods, habits and other incidents of life, being daily and continuous, must have much more influence on constitutional tendencies than medicine and treatment, which is occasional or varied. Perhaps the clews to the two opprobria of the profession—consumption and cancer—are to be conquered after all by means of food.

Richard Bissell, the naturalist, who died recently in Cincinnati, was a candid man. In his autobiography occurs this passage, referring to one period of his life: "Subsequently I practiced the humbuggery of medicine, which is experimenting and guess-work, like a half-blind man going out to shoot birds or rats. I refer to doctors, not surgeons."

A New Yorker who recently visited Canada, was pounced on by a sanitary officer who insisted on vaccinating him. It never occurred to the protesting traveler to inform the officer that he had had the small-pox once, and the vaccination was duly performed.

The existence of a leprosy in New Brunswick, on the Miramichi river, in a low fishing population, and upon Cape Breton Island, has been for some time familiar. Contagion seems to have been clearly proved in the former settlement, but in the latter all cases are the descendents of one woman, a significant suggestion of precautions which should be taken in eradicating the disease. In the United States several cases of the disease have appeared among Norwegians in the Northwest, particularly in Minnesota. Nearly all the cases are of those infected before their arrival, but a well-authenticated instance of the transmission of the disease by descent. It has also appeared at intervals since 1846 in Charleston, S. C., while in Florida it was prevalent more than a century ago, and the large number of cases in Louisiana in 1875 required a special hospital. In 1866 it reappeared in Vermillion Parish, in that state, and other cases are now there. In California and Oregon the Chinese emigration has, as might be expected, introduced the disease.

In India itinerant eye-doctors go from town to town crying their professions, which they practice right in the open square. Operations for cataract they perform with the utmost celerity, using a common penknife, and very generally with excellent success.

The Governor of Illinois recently appointed Charles W. Day, of Wabash, a member of the State Board of Pharmacy, to succeed himself. Mr. Day is at present the Secretary of the Board.

A law in Georgia provides that poisons must be put up in scarlet wrappers, and bottles be labeled with the same color, the printing to be in white letters.

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#### Articular Rheumatism.

Dr. F. W. Stewart, late assistant physician to Milwaukee County Hospital, reports excellent results from the use of Lambert's Lithiated Hydrangea in the treatment of two cases of complicated articular rheumatism due to excess of uric acid in the system, and which had resisted the remedies usually prescribed in such cases. The lithiated hydrangea was administered in one drachm doses, three times daily; the effects were prompt and satisfactory, a complete recovery resulting after two week's medication and diet.

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# THE PEORIA MEDICAL MONTHLY.

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## ORIGINAL COMMUNICATIONS.

### BLOOD: AND THE VITAL ENDOWMENT OF TISSUE.\*

BY O. K. REYNOLDS, M. D., KANE, ILL.

Step by step, as the ages pass by, does the soul of man come up out of the darkness of ignorance and superstition into the light. Slowly but surely the laws of evolution bring forth order out of chaos: and without haste, and without rest, the sublime processes of development proceed according to the will of God, backed by an energy that is irresistible and which no power can obstruct or turn aside. Results that require millions of ages for accomplishment are as absolutely certain to be brought about as the simplest acts of men requiring only a few moments of time to accomplish.

Every leaf that falls in the lowly forest, every storm-wrecked monarch of the woods that falls to the earth, every drop of water that falls from the clouds, or fills the rivers, or replenishes the ocean, is a factor in the problem of the universe. We are convinced by laws, both physical and spiritual, from which we cannot escape and which we must obey or suffer. Mysteries surround us on every side. The grass that grows, the flowers that bloom, the precious fruits of the earth, the rocks, the mountains, the earthquake, the storm, and all the wondrous phenomena of the physical world excite our astonishment and awe; but

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\*Read before the Medical and Surgical Society of Western Illinois, at Carrollton, January 5, 1886, and ordered printed in the PEORIA MEDICAL MONTHLY by a vote of the society.



how much greater and more wonderful are the phenomena of *Life*; the manifestations of which we see around us every day.

The subject of the present essay involves the consideration of this mysterious thing called *Life*. Without regarding its phenomena and laws no intelligent diagnosis or prognosis can be made, and no rational treatment of any case of disease formulated. For example, let us examine a dead human body, where death was caused by sudden shock, without appreciable anatomical lesion. There lies the body, perfect as in life; it has eyes but they see not, ears but they hear not, feet but they walk not. All the organs are there intact, but their functions have ceased; there is no more digestion, no more assimilation, no more circulation, no more secretion, no more calorification, no sensibility, no motion. Here is a case in which all medical schools can harmonize. Elaterium will not purge, diaphoretics, diuretics, tonics, depressants, narcotics and the entire list of medicaments are useless. Here the disciple of Hahnemann will agree that his powerful attenuations will fail, and the Eclectic cannot resurrect the cadaver with Skunk Cabbage or Lobelia. The Hydropath, the Physiopath, the Uropath, and last of all the Allopath can harmonize perfectly in this consultation and hand over the corpse to the smiling undertaker, while they proceed to go for the assets of the deceased. Now, what constitutes the difference between this body and the same body six hours before? One word expresses it, *Life*. Now what is life? Can you tell? Can I tell? Can anybody tell?

The nearest approach we can make to an understanding of this sublime secret of Almighty God, is by watching its manifestations as they appear in the different vital processes of the living body, and especially in the blood and nervous system. Now what is blood? The physiologist will tell you that it is a compound, partly organic fluid, found in most living animals; that it is necessary for the manifestation of life, and that it is composed of red corpuscles, white corpuscles and a plasma composed of albumen, fibrin, serum, earthly salts, etc.: especially the etc. This is quite definite and highly satisfactory, but here comes my lord, the chemist. Let us hear from him. Oh, yes, says the chemist, blood is composed of—

Water,	835.00
Globuline (So?),	141.11
Hæmatine (So?),	16.75
Fatty Substances (So?),	3.72
Undetermined extractive matters (So?)	3.94
Fibrin,	4.05
Albumin,	78.84
Chloride of Sodium,	} 8.55
Chloride of Potassium,	
Phosphates of Soda and Potassa,	
Sulphate of Soda and Potassa,	
Phosphate of Lime,	
Phosphate of Magnesia,	

Bravo, Sir Chemist! You have undoubtedly got it down fine; yea, very fine: yea, most exceedingly fine, and since your analysis is so wonderfully precise, perhaps you will oblige us by a synthesis equally correct, and reconstruct this blood for us so that it will appear before us precisely as it was before the analysis. Oh, no, gentlemen, not to-day: some other day: good day, gentlemen, I have an engagement. The truth is that the chemist can neither analyze nor reconstruct the blood. He can only give names, and giving names don't explain much or make things any clearer than they were before. Well, since our modern science fails, let us go back and ask Moses, and he claims to tell us what he has received from a higher power. See Leviticus, Chapter 17, verses 12 and 14:

12. Therefore I said unto the children of Israel, no soul of you shall eat blood, neither shall any stranger that sojourneth among you eat blood.

14. For it is the *life* of all flesh, the blood of it is for the life thereof, therefore I said unto the children of Israel, ye shall not eat the blood of *no manner* of flesh, for the life of all flesh is the blood thereof; whosoever eateth it shall be cut off.

The above, whether from divine or human authority, contains truth which ages of investigation have failed to controvert. The blood is indeed the life of the body, or the source of its life, and contains all the elements necessary for the upbuilding, the support and the repair of the body: and it also carries the products of retrograde metamorphosis which are in themselves excrementitious to the proper organs whose work it is to eliminate them from the system. But the point which I desire to elucidate is that in order to perform these functions the blood is and must

be *alive*, and that it also transmits to the nervous system and all the tissues a portion of its own life, thereby communicating to them a vital endowment, whereby they become susceptible to irritation, and capable of manifesting the phenomena of congestion, inflammation, excitement, hyperæsthesia, and their opposite conditions.

We come now to inquire from whence comes this life? Two conditions are necessary for its production. What are they? Contact of pure air with healthy blood in a perfect organism. About all we can learn concerning this most mysterious operation is that during its passage to and from the lungs the air loses oxygen, and receives carbonic acid: and that after expiration it must receive more oxygen before it is fit for inspiration or can sustain life. There is no doubt whatever that by this contact of air and blood in the lungs a vital electricity is evolved or generated, and I believe is the copula, or connecting link between the spiritual and natural. Furthermore, a fact which I consider of the utmost importance has been positively demonstrated by experiment, and the knowledge is acted upon every day in electrical practice, viz.: that this same animal or vital electricity is subject to the same laws of *polarity* and *attraction* and *repulsion* that governs the ordinary form of electricity. I will refer to the conclusions which result from these facts further on.

As the manifestations of life result from an effect produced upon the nervous system and various tissues of the body by this electro vital or animal electricity, and as this agent is only produced by contact of pure air with healthy blood, it follows as a consequence that any changes of blood or air from the normal standard will produce either a qualitative or quantitative change in the electro vital agent and as a necessary result the manifestations or phenomena of life in the body must also change. The doctrines herein held by me can best be manifested by a few short propositions as follows:

PROPOSITION I.—There is a vital endowment of tissue, without which the phenomena of life cannot be manifested in the human body, and in the absence of which there can be no morbid action, and no disease.

PROP. 2.—This vital endowment of tissue remains perfect so long as pure air is brought in contact with healthy blood in a sound living body, but ceases soon after the cessation of respiration.

PROP. 3.—Its manifestations vary constantly with the qualitative and quantitative changes of the blood: it is therefore altogether probable, if not absolutely certain, that the tissues receive their vital endowment from the blood, and that the blood is vitalized in its passage through the lungs.

As the contact of copper and zinc with an acid evolves, generates or liberates the galvanic current, so does the contact of pure air with healthy blood in the living organism evolve, generate or liberate a force, aura, or animal electricity, which is carried by the blood and nerve radicles to the brain and spinal cord. This animal electricity vitalizes first the blood, and through it the tissues, and in truth the lungs are the battery where this force is evolved, the brain and spinal cord are the Leyden jar or reservoir in which it accumulates; the cerebro spinal nervous system furnishes the telegraphic wires through which the mandates of the will are sent to all the motor apparatus of the system, and sensation conveyed to the brain by the different branches. The organic nervous system, so long as it is supplied with this vital electricity, presides over secretion and innervation. I also believe that the nervous system of organic life unites, harmonizes and presides over the involuntary processes which continually go on in the body, and which keep the wheels of life in motion whether we sleep or wake.

The human body when dead tends to putrefaction and speedy disorganization, but the body may live for 100 years: therefore this vitalizing force is conservative, resisting the power of chemical forces which are antagonistic to the life power, and which if left to themselves would by reason of the very slight cohesion and weak affinities of the soft parts, speedily reduce them to their original elements.

In almost every case of disease there is, either first or last, primarily or secondarily, change or alteration from the individual standard of healthy blood. This fluid may be altered either qualitatively or quantitatively.



The quantitative changes may affect one or more factors, or the whole; the qualitative changes usually affect the entire mass. The latter changes may result from—

- 1st. Bad pabulum furnished the digestive apparatus.
- 2nd. Organic lesion of one or more organs belonging to this apparatus.
- 3rd. Excrementitious matters retained in the blood because not eliminated by the proper emunctories, such as urea, uric acid, bile, etc.
- 4th. The sudden evacuation or draining away of necessary elements of the blood, as serum in cholera, and albumen in albuminuria.

As there is a certain amount and kind of action present in each part of the body during health, so this action may be increased, diminished or altered. Here then begin the manifestations of disease.

Certain foreign substances when introduced into the blood increase action in a part or the whole organism. These are called stimuli. They may effect this increase of action in two ways:

- 1st. The blood lacking the normal quantity of certain of its proper elements, by having these restored has its power of evolving the nerve force or animal electricity restored to the healthy standard; the vital endowment is thereby improved, and the vital actions which were before below par are now restored to their normal activity. To this class of articles belong *Restoratives proper*, as iron, alkalies, acids, phosphates, etc., also food; they are also indirectly stimulants. Catalytics also belong to this class.

- 2nd. Articles which are not essential to the composition of healthy blood, such as alcoholic liquors when given within certain limits increase all the vital actions.

How may this be done? By increasing the evolving power of the blood, as sulphuric acid increases the evolving power of the solution in the galvanic battery. Thus the blood evolving more rapidly the vital electricity, the vital endowment of tissue is improved, respiration and circulation become more rapid, and if the blood was at the normal standard before the introduction of this foreign substance, then the vital actions will *transcend* the

bounds of health and we will have the condition of morbid excitement or overstimulation. In like manner true sedatives may act by diminishing the evolving efficiency of the blood.

One peculiarity of blood affections is that they tend constantly to grow worse, *e. g.*, it is the function of the liver to secrete bile; this fluid in health has a certain fixed composition; any change therefore of structure in the organ, of quality in the blood, or of innervation in the nervous system of organic life, which presides over the organ, will produce a change in the bile, elaborated. If the bile is not of good quality it cannot perform that part in the digestive process which was its function, *ergo* chyle manufactured with such bile is not as it should be: the blood receiving a supply of bad chyle is altered or impoverished and the furnishing of that bad blood to the previously disordered liver renders the next supply of bile and chyle still worse than before.

This is so in most cases where the blood as a whole becomes involved in changes of quality, and especially in most lingering *chronic* diseases, as also in septic fevers of all forms.

As this article is already too long I will close by summing up the results that can be effected by medicines and stating the boundaries of remedial action:

1st. Vital actions in an organ, a part, or the entire system, may be *increased, diminished or altered*.

2nd. Foreign deleterious substances in the blood may be *neutralized* and rendered innocuous, or *eliminated*.

3rd. Elements necessary to the constitution of healthy blood having been lost or diminished in quantity may be *restored*.

4th. The polarity of an organ or part, when changed and abnormal, can be restored by the ordinary form of electricity applied according to Clark's theory of electrical action.

The above statements embrace nearly, if not entirely, the whole story of therapeutic action.

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Subscribe for the PEORIA MEDICAL MONTHLY, a practitioner's journal; \$2.00 per annum.

SOME OF THE CAUSES OF RUPTURE OF THE  
OS UTERI.

BY W. E. GILLILAND, M. D. COATSBURG, ILL.

Read before the Adams County Medical Society.

The subject which I have chosen to call your attention to to-day, need not be protracted to a tiresome length. I propose to present you with a few thoughts upon some of the causes of rupture of the os uteri. Of course you will understand, that if I were to go over the whole grounds covered by the causes of this accident, it would require the writing and reading of quite a monogram. I prefer, therefore, to limit myself to such cases as are usually termed normal labors. I understand by that, such cases as terminate without surgical interference.

The first question that presents itself to our minds is—can a rupture take place in a normal os uteri? Our answer to the question is no, and yes. When it is perfectly normal as to both condition and position, we answer no. When perfectly normal as to condition and abnormal as to position, we answer yes. These answers must both be taken as relating to the unaided, natural efforts of the mother to give birth to her child. We recognize the fact that an os uteri may be rendered so friable by disease, or so contracted by cicatrization, as to render it impossible that it should dilate sufficiently to allow a child's head to pass without rupture, but this is outside the limits of our paper.

The case supposed for your consideration is, what I shall denominate a sacculated or hooded condition of the occiput. Many of you, perhaps all, have been called to cases of labor where the pains have been coming on for a considerable time, from three to six hours. Of course you know nothing about the progress of the labor until you make an examination; and when you do make it you are surprised to find that such pains have accomplished so little: in fact you are in doubt as to whether the pains are not spurious, and that the labor has not begun at all. What is the cause of this doubt? The head seems to be fairly engaged in the pelvis, and forms a well-defined rounded tumor in the upper part of the vagina, but you fail with one finger to reach or find the os, or determine anything in relation to its condition. The whole presenting part of the child is covered up

with the thick, fleshy anterior lip of the mouth of the womb. When the next pain comes on you determine to find it, if it is anywhere in the vicinity. You introduce two fingers or the whole hand and by a kind of climbing process with the fingers, you ultimately reach it or bring it within reach. It was tucked away up in the posterior vaginal cul-de-sac, apparently in the hollow of the sacrum. You find it dilated about enough to admit the passage of a shoe button, and even at this early stage, it was so elongated from before backward, or if you prefer, from above downward, that it more resembled a button hole than an os uteri. Now here is a case that usually passes under the name of rigid os, but there is something more the matter here than rigidity: in fact there seems to be but little or no rigidity about it. The forces intended for dilating the os are spent upon another part. Now what would you do in this case? Dr. Dilatory says he would give her a dose of chloral and go to bed, and in the morning she would be all right. Dr. Conservative says he would wait a couple of hours and see what nature will do. After a couple of hours he makes another examination and finds things much in the same condition. The head pressing a little lower down, the elongated os a little more dilated. He reports to his patient that she is having a "tedious labor." This bit of information is hardly necessary, for she is fully aware of the fact that it is not only tedious, but exceedingly painful and unsatisfactory. The doctor relapses into another two or three hours of conversation. At the end of this time, another examination reveals the facts, that the head is still lower down, even pressing on the perineum: the os has made an appreciable advance toward dilation, but the anterior lip is still tucked up over the occiput of the child, to the anterior fontanelle, after the fashion of a child's hood. This presenting portion of the uterus is now strangulated between the os pubes and the child's head, and so swollen that it is about as thick as the little side of our hand, and of a dark, livid color. This congested œdematous condition depresses the vitality of the parts, and renders them friable and easily ruptured, and interferes with the process of dilation. The normal, lubricating and emolient secretions are dried up, the parts, in a condition bordering on inflammation, are rendered



exceedingly sensitive. The pressure of the child's head upon this abnormally sensitive part, excites the reflex repulsory effort to the highest pitch. The pain renders the mother frantic and she begs for help at any cost. Her efforts to relieve herself are terrific, and while one of her super-human efforts is at its height she lunges backward upon the bed, utters a scream, and then exclaims "that it is all over." So great is the relief that she imagines that the child is born. Now what has occurred here? There may be nothing very serious, but most likely there is. Some damage may be done to the uterus or some of its appendages, but just how much can only be determined by a careful examination, or even repeated examinations after the child is born.

We have had a condition here that might give rise to one of several pathological conditions. Dragging or forcing the uterus so low down in the pelvis, puts its ligamentous and cellular attachments upon the stretch, in so much that it might excite inflammation, giving rise to peri-uterine cellulitis. Or should some of these tissues give way and a smart little blood vessel be ruptured, a pelvic hematocoele would be the result. But our subject is rupture of the os uteri. An examination will now reveal the fact that the head has escaped from the mouth of the womb; and if rupture of the os has taken place it will be stained with blood, and there may be a smart discharge of blood from the vulva. With a few more pains of a much milder and more satisfactory character, the child is born; and with considerable, though not alarming hemorrhage, the mother is put to bed in an extremely exhausted condition. Your patient is now in too much of an exhausted condition to admit of a careful and definite examination, and begs to be let alone; which, after all things are considered, is perhaps the best thing that could be done. Now while she is making a slow and tedious getting up, to find herself a confirmed invalid, let us speculate a little more about what has occurred. The anterior lip may possibly have slipped off the child's head and assumed its normal condition and position, and no harm has resulted. We are always willing to make proper allowances for the wonderful resources of nature to right her wrongs, but in such cases she is not always to be

trusted. Suppose it did not, then what may have occurred? A rent in some part of the circle of the os, reaching back from the border to or even beyond the utero-vaginal junction, by which the child's head was allowed so suddenly to emerge from its confinement, is about the most likely thing that could occur. This rent may occur in any part of the circle, but it is more likely to occur upon one of the lateral borders, just where the congested portion joins the exsanguinated portion, and possibly, it might commence simultaneously on each of these borders, forming the so-called bi-lateral fissure of the os. But our patient is now up, and finds herself, as she supposes, an invalid for life; but still entertaining hopes that there is a balm in Gilead, she spends a year or two in being transferred from one physician to another and in greatly exhausting her husband's exchequer. Ultimately she falls into the hands of one of our modern gynæcologists and has her injuries repaired as far as may be, and her condition rendered tolerable.

Now could this injury, all this suffering and all this expense have been avoided? We answer that almost without an exception, it could. In over 800 labors it has never occurred with me. Well, how could it be avoided? The how is very simple and easily told; but we are quite willing to admit that it is not always quite so easily executed. The answer is, hook the finger or fingers if necessary into the mouth of the womb, and bring it downward and forward, over the child's head, and adjust it to the presenting portion of the occiput, and retain it there until it is willing to stay there unaided. This may be very easily accomplished and it may not. If it is, it will be interesting to note the changes in the character of the labor—how much more satisfactory to the patient, and how much more effective in dilating the os. On the contrary it may be more resisting, and manifest a disposition to return to its former position and condition as soon as you let go of it; and it may require perseverance for an hour or two, or until the os is pretty widely dilated before you can say that you have thoroughly overcome it. In the mean time your patient will find out that her pains are much more satisfactory while the os is so adjusted and she will insist on your helping her. 'This hooding of the anterior lip must be overcome.

There is too much risk to allow it to go uncorrected, and you owe it to your patient that everything possible be done to guard her against such risk. I am satisfied that all of you who have any obstetric practice at all, will meet with the condition above described: then you will think of what I have told you. Your minds being called to the pathological condition, your judgments will furnish the remedy.

I now come to speak of a cause of rupture of the os uteri that I have recently discovered. Three months ago you could not have made me believe that such a cause existed. My readings upon the science and art of obstetrics has been quite extensive, and I have never seen it mentioned, or heard it hinted at. I think that it is not extensively known among the profession, and I sincerely hope that it is not. Now, Mr. President, in speaking of this cause of rupture of the os uteri, I may tread upon the corns of some of my medical brethren, but let me assure you and them, that I will do so as lightly as possible, and with the kindest of feelings for all. I am always ready to crave due allowances for my own weaknesses, and am equally willing to accord the same to others. I prefer to tread upon the tender corns of my professional brethren in preference only to the more tender corns of our wives and the mothers of our babes. He who shows us our faults is our friend. If we show up each other's faults here in the medical society, then are we all friends. This must suffice for an apology for introducing this subject here.

The cause of rupture of the os uteri now to be considered is *the turning of the child by podalic version after the child's head has escaped from the mouth of the womb*. I think I hear some of you saying "Stop! Hold on! Did not you promise that you would confine yourself to such cases as are terminated without surgical interference?" I beg pardon Mr. President; the cause mentioned, as I will endeavor to show further on, is the most unscientific and unsurgical that you ever heard of.

A very respectable and intelligent young physician comes up before the Adams County Medical Society, and makes a verbal report of a remarkable case of labor that occurred in his practice, in which the os uteri became firmly contracted around the child's neck after the head escaped the os. This is a condi-

tion which is not so extremely rare, but when it does occur, it requires a great deal of patience, and may tax the skill of the accoucheur to the uttermost. But he tells us that he attempted to introduce his hand for the purpose of turning by the feet, but could not, by reason of the firm contraction of the os. That young man ought to be everlastingly grateful to that os uteri for resisting his uncouth, unscientific and unsurgical procedure. If it had not, he might have committed a blunder that would have been a foul blot upon his fair reputation, and a cause of regret and remorse as long as he lives.

After this an older physician of equal respectability and intelligence, one who has acquired almost a world-wide reputation as a surgeon, and one who aspires to be a teacher of the alumni of our colleges and is reputed as one of high authority on surgical questions, comes before the Adams County Medical Society and tells us that in a similar case he actually did, with his herculean strength, perform this operation. And he further tells us that os uteri was split. That the vesico-vaginal septum was split, from where it joins the body of the uterus, away down to within an inch or an inch and a quarter, of the meatus urinarius.

Now gentlemen, I wish you to note carefully with me the steps of this operation. I would first call your attention to the facts that the child's head is in the vagina and occupies the lower strait of the pelvis; the body is in the womb, and the mouth of that womb is so firmly contracted around that child's neck as to render it utterly impossible to deliver it with the forceps. Everything being now ready, he introduces a tolerably large hand into the vagina while it yet contains the head; for if he could not deliver the shoulders from above he could not replace the head in the womb from below. But the hand progresses onward and upward. It passes the os uteri while it yet contains the neck. The progression still proceeds. The hand is now in the womb with the body of the child, the wrist is in the os, and the larger part of the forearm is in the vagina with the head. Now the reverse motion begins. The clenched hand, containing the feet, comes down and is made to traverse that contracted os while it yet contains the neck. After this comes in succession the legs, the knees, the thighs, the breech, through this con-



tracted os. Now let us stop and look at it a little while it is in this position. The feet, legs and greater part of the thighs are delivered through the vulva, the vagina contains the head and the breech, the os encircles the neck and waist, and the womb contains the chest and shoulders of the child. Now, gentlemen, there is a spectacle for the gods. Ah, Esculapius, what a capaciousness of vagina was there! Oh, all ye gods in medicine! What a dilatation of a contracted os uteri was there!

Now the thorax and shoulders of the child are made to follow the breech and body and the nape of the neck is the last to free itself from the os. The feet, legs, thighs, breech, body, thorax, shoulders and the neck are made to pass the head while it is imbedded in the—the wall of the vagina? in the bladder? where? And the head is the last part delivered. We are told that the os uteri and the vesico vaginal septum are split. Is it surprising? And the child for lack of attention was lost. Is that a cause of wonder? This child was doubled up in the uterus, made to pass out through the spasmodically contracted os in a doubled up condition, turned end for end in the vagina, and is delivered feet first.

Now, gentlemen, what shall we say of this operation? I confess upon my part that I have not language sufficient to do it justice. Suffice it to say that I condemn it, in toto. If I had attempted to perform that operation I should have expected that my patient would have been "split" from the ensiform cartilage to the point of the coccyx, and before a man could have put two shells in a double-barreled shotgun and got ready to shoot I would have been out of gun-shot, and the next day I would have been rustivating with the ex-bankers in Canada.

But what was to be done? Would you abandon your patients and let them pass over the dark river together? Nay! Verily! Well, what would you do? The younger man of the two struck the key note, but he failed to discover the principle. He, by a protracted, super-human effort, with the forceps succeeded in delivering his patient. How? By tiring out the contraction. Persistent force, applied in the right direction, will soon tire out or overcome any spasmodic contraction of the os or any other part of the uterus, that I have ever seen. If the os has

been sufficiently dilated to allow the passage of the head, it is a strong argument in favor of the theory that it can be made to dilate to allow the passage of the shoulders. Should such a spasmodic contraction take place after the head has passed, and it should be discovered, an attempt should be made immediately to deliver: for the longer the spasm is allowed to continue the firmer and more resisting it will become. If our friend could introduce his hand into the vagina, and then through the os, dilating it sufficiently to admit the passage of the hand while it yet encircled the neck, I cannot see, for the life of me, why he could not have withdrawn his hand, applied the forceps, and delivered before the os had time to again contract. Or, failing in this, if the contracted os was so easily "come-at-able," could he not have introduced a pair of scissors, and made several little nicks in it, as is recommended in some of our standard works on obstetrics, in case of unyielding contraction before the head. But I am of opinion that there was another factor in each of these cases that was entirely overlooked by the gentlemen. Should the shoulders of the child come down antero-posteriorly, I know no reason why the anterior shoulder might not hang upon the brim of the pelvis, in the same manner as the chin does occasionally in breach presentations, and become a serious hindrance to delivery with the forceps, unless it be corrected. Such a condition might be very misleading. An obstetrician might think he was exercising a tremendous force against a contracted os, while he was really exerting it against the os pubis or brim of the pelvis. The remedy for this condition would be to change the shoulders to the oblique direction in which they should enter the pelvis. If the hand could so easily be made to pass the head in the vagina, as these gentlemen would make us believe, I can not see that there would be any great difficulty in making the change: but I must confess that I have found the vagina of a woman a very limited field to work in, while it contained the head of a well developed child at term.

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Dr. T. Addis Emmet, of New York City, has been elected an honorary fellow of the Academy of Medicine in Ireland.

## THEORIES OF THE PRODUCTION OF THE SEXES.

BY SILAS HUBBARD, M. D., HUDSON, ILL.

(CONTINUED FROM JANUARY NUMBER.)

Dr. Funkhouser, of St. Louis, is reviving the theory that the right testicle produces males and the left females, while the ovaries have no particular effect in producing either sex. I will make a few remarks as regards how each testicle may have some influence in the production of each sex. The right side of the body and the right testicle usually are stronger than the left, hence the spermatozoa secreted in the right testicle are stronger and more active than those of the left. Therefore they would have more power to make their way up the fallopian tube to the ovary than the left, and would have ordinarily more power in begetting a male than the left. The right testicle ordinarily hangs higher in right-handed men than the left; but in left-handed men usually the left testicle hangs the highest; and in such cases the left side and the left testicle are usually the strongest, consequently in that case the spermatozoa secreted would have a greater aptitude to beget boys than the spermatozoa secreted by the right. In the last December number of the *Medical Brief* is an account of a man seeking to obtain a divorce from his wife because she produced a boy while he had only a left testicle. William Dodge, M. D., in commenting on the case says: "I know of a stallion with but one testicle that begets male and female progeny in about equal number. Why not man?" I would say that if a man has only a left testicle, that nature has so provided that that testicle shall take on superior power to supply the deficiency of the right, hence the left testicle in that case would acquire a superior aptitude to secrete spermatozoa with sufficient vigor and activity to make their way up the fallopian tube to the ovary, and there impregnate an immature ovum which would develop into a boy; but usually, the right testicle being more vigorous than the left, procreates both sexes.

The medical public did not know that twins blended were always of the same sex until I announced it in the *Buffalo Medical Journal*, Vol. 7, p. 546. I will make use of the above knowledge to prove that those physicians who say that the

spermatozoa are male and female, and which ever gets possession of the ovum decides the sex of the child are in error; for such twins must have come from a double-yolk egg, and it would take two spermatozoa to vitalize both yolks, one for each, and if the spermatozoa are of both sexes, it would sometimes happen that a male spermatozoid would vitalize one yolk and a female the other at the same time, and thus we would have a male and female blended; but the like never occurs. Therefore we would infer that the sex of the child does not depend on any sexuality of the spermatozoid. If in the case of the double-yolked egg but one yolk is fertilized, but one individual is developed, the other yolk dies. If one is fertilized in an immature state it develops into a male, and if time elapses and the other is impregnated in a mature state, as a superfetation, it grows to be a female; but the impression the two yolks got at different times and under different conditions, would make them develop into separate individuals. In order for them to blend, both yolks would have to be fertilized at the same time, while of the same age and in the same condition.

There is an ovum formed about the menstrual period, which period is analagous to the heat of animals, and the reason menstruation is given to women is to purge the system preparatory to gestation, and to deplete the genital organs so that women should not, like animals, show by actions or manners that an ovum is formed and ready for fecundation. If a woman is impregnated during menstruation the child would be a female, because at that time the action of the fallopian tubes would be towards the uterus; hence spermatozoa could not ascend up the tubes to meet an ovum, but having some power of motion of their own, they could maintain an existence within the uterus until the menses subsided and an ovum came down into the uterus, and there met with a spermatozoid and became impregnated, and would thus develop into a female. Dr. James S. Hawly, of Buffalo, N. Y., related to me such a case.

Woman was originally created from man, and now she is created from what would have become a man if impregnated sooner. Man was originally created before woman, and so far as growing from an impregnated ovum is concerned is still cre-



ated first. The very early impulse the ovum gets in the immature state causes him to grow larger, and coarser, and stronger, and rougher in mind and body and head, than the woman: while the deference of impregnation of the ovum to a late date has a refining influence, and thus the ovum develops into a being with a finer, smoother head, and body, and mind and soul than man possesses on an average. However, in the resurrection they will both be "as the angels in Heaven"—neither male nor female. So I should judge from Scripture.

The spermatozoa of different males may come in contact and communicate diseases to each other and to the ovum which could descend to the offspring: yet no two spermatozoa of different males, or even the same male, can vitalize one ovum: thus a plurality of males cannot be the sires of one and the same offspring.

Dr. Hough seems to have demonstrated that men usually inherit more of the constitution and temperament of body, soul and mind of the mother than of the father, while women usually inherit more of the aforesaid qualities of the father: but he accounts for it on very different principles from what I do. I will account for it according to my theories as follows: The immature ovum is distant in the ovary or fallopian tube and thus in consequence of its immaturity and distance it comes less under the influence of the father: the spermatozoid being considerably exhausted by age and traveling in reaching it, and thus the father, having furnished less of himself to the ovum, the mother takes it physiologically in hand at this early date and impresses her constitution on it in a superior degree; while a daughter comes from a mature ovum which has reached the uterus before it is impregnated, and is thus near of access to the spermatozoid while it is fresh, and thus he gives it a greater impression of himself than he did the ovum which developed into a boy, and thus the daughter inherits more of his constitution psychally and physically perfections, diseases, and infirmities, than does the son.

The queen bee which has never been impregnated produces nothing but drones, and if I here had time I could show how all drones of the bee kind came from ova which had never been impregnated. I could also show how the workers are fe-

males as well as the queen, and what brought about their difference. We cannot always reason analogically regarding the attribute of different species of animals, if what the *Popular Science Monthly* (Vol. 3, p. 399) says is true, viz: That female shrimps come from unfecundated eggs, and males from fecundated eggs. If it is true as the *Popular Science* (Vol. 4, p. 761) suggests, that among certain low species of animals a difference of sex can be produced by a difference of nutrition of the parents, it does not follow that the law applies to the higher species of animals.

Dr. Hough informed the late Dr. Parry that I had conjectured that there were a larger number of males in extra-uterine fetations than females. Dr. Parry hunted up eighty cases where the sex of the child was reported, with the result of 47 males and 33 females, which strengthens the truth of my conjecture. I have collected seven cases, five of them boys and two girls. I have collected seven cases of placenta previa in which the sex of the child was reported, and the result was five girls and two boys, which favors my conjecture that the largest number of the children in such cases are females. Dr. Hough collected 81 cases with the result of 41 boys and 40 girls. Physicians do wrong in not generally reporting the sex.

Dr. Hough says statistics show that women possess more vitality than men: one reason may be that the ovum which grows to be a female was vitalized by a fresher and younger spermatozoid than the one which developed into a male. The ovum from whence the female develops is more mature at the time it is impregnated than the ovum that develops into a male, and dating from that time she continues more mature through life at the same age.

Very commonly those women who bear girls have somewhat of a pendulous abdomen, or it projects anteriorly during gestation, while those women who usually bear boys have such vigorous abdominal muscles that the uterus is held back and they seem equally full all around. Hippocrates, Galen, Aristotle, Avicena and Sebiz say, "The woman who carries a boy will usually have a better color, a better appetite, be lighter in her movements, and experience less malaise in general than one who carries a female." I think they are generally correct in the

observation, though I think, contrary to them, that the sex of the child was the principal cause. Weakly women usually bear girls, and vigorous, active women usually bear boys. The only way a difference in the sex of the child could make any difference in the feelings of the mother would be by a difference in the location of the placenta and its superior size and expansion as connected with the girl, and that girls oftener lay cross-wise and oftener present lower extremities and breech first. I will also say that the placenta of a boy being usually situated higher in the uterus than the placenta of a girl, nature has ordained that usually the cord should be longer. Thus it oftener prolapses, and to compensate for the comparative deficiency of the placenta of the boy he is connected with a greater expanse of the membranes, thus there is usually a greater amount of amniotic fluid accompanying him than a girl, and because there is usually a less amount of water with a girl the mother is more sensitive to the movements of a girl, and therefore would seem to quicken sooner with a girl than with a boy.

I would expect more extrauterine fetations on the right side than on the left, because the fallopian tube is weaker on the left side than on the right, and therefore would be more likely to lag and hence more likely to fail in pushing the ovum into the uterus.

Some kinds of birds ordinarily lay but two eggs, and when hatched, one is usually a male and the other a female; this is because one egg was formed in the right ovary and the other in the left, the right ovary furnishing the female and the left the male; because the right ovary being more vigorous would mature an ovum sooner, therefore it would develop into a female, and the left ovary being weaker would lag in maturing an ovum, consequently it would develop into a male. The same reasoning would ordinarily apply in regard to the twins of women, mares, cows, sheep, etc., when they are of different sex: but where they are of the same sex it would usually be because both ova were matured and impregnated at the same time. It can be seen from these remarks that there is rather a tendency of the left ovary to furnish males and of the right to furnish females.

I know a young man whose testicles are so atrophied that there is scarcely anything left of them but the epidymis. I am

sure that they could secrete so very few spermatozoa that not one of them could be expected to enter the fallopian tube and be carried to the ovary, and according with this he did have a daughter born to him one year after he was married.

In those very rare cases of imperforate hymen where pregnancy does occur the child would likely be a female, because the very few spermatozoa admitted into the vagina through a crow quill hole could not travel the whole length of the vagina and uterus and fallopian tube and impregnate an immature ovum in the ovary, consequently it must have been in the uterus at the time of impregnation, and therefore was mature, and therefore developed into a female. Dr. J. Little, of Bloomington, Ill., relates one such case in the *PEORIA MEDICAL MONTHLY*, Vol. 2, p. 48. He informs me the child was a girl. He also said four or five other cases had been reported, but as usual the sexes of the children were not given.

If a woman has just recovered from sickness and becomes pregnant, the product will usually be a girl, on account of a lack of physiological power to help carry the spermatozoa up a fallopian tube to a new ovum.

The regulation of the production of a male with man can be made more certain than with quadrupeds, for I have said that boys are usually conceived during the last half of the intermenstrual period, and the menses coming on and lasting four or five days make a demarcation line between the time of begetting a boy and a girl. The semen which was deposited in the uterus shortly before the menses cannot stay there four or five days during the menses until they cease and a mature ovum arrives in the uterus, for the menses would wash it away; hence if an ovum was impregnated shortly before the courses it must have been by the semen having passed up the fallopian tube to the ovary out of the way of the menses. But sometimes, with some quadrupeds, the horse for instance, there being no flood line corresponding to the menses, a weakly stallion may have congress with a mare in the beginning of heat, and the semen be deposited in the uterus, and instead of passing up the fallopian tube to the ovary and impregnating a new ovum, it stays in the uterus and impregnates an ovum after it has become mature and



come down in the uterus, sometimes days after the congress, thus producing a mare colt, contrary to our usual expectation.

I will here briefly allude to some things I have heretofore said and given the reasons for, viz: That very young males and females, whether man or beast, produce more females than males: that middle-aged males and females produce more males than females: that horses and sheep beget more females in the beginning of the rutting season, and males in the middle, and again more females in the last of the season: also, those animals, whether man, bird or beast, that live in a state of polygamy, produce more females than males: also that fish as usually raised artificially are mostly males. The aphis produces males in her last generation, and females in eight previous generations, all from one sexual congress. Dogs, and cats, and wolves, usually produce more males than females. More girls are born in the city and more boys in the country. During cholera times more girls are begotten than boys.

The feet of very many Chinese women are so compressed that they can exercise so very little is a reason they have more girls than boys. The Hindoo women are so oppressed and depressed that they have more girls than boys. The North American women are so laborious and industrious that they have more boys than girls.

[CONCLUDED NEXT MONTH.]

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## COMPOUND, COMMINUTED FRACTURE OF FEMUR.

BY J. P. WALKER, M. D., MASON CITY, ILL.

November 27, 1885. I was called to see Claude Bricker, aged 16, healthy, son of a poor widow dependent for subsistence for self and children on her own and daughter's work.

I found him pale, almost pulseless, with severe shock: compound comminuted fracture of the right thigh, about the junction of the upper and middle thirds. The fracture was extremely oblique, the oblique ends of both fragments broken off about one and one-half inches each: these pieces were almost detached from their relations to the soft tissues, the injured limb lying

across the other nearly at a right angle: the lower fragment had torn through the muscles and skin on the outer side of the thigh, and the upper fragment through the posterior face of the ham: profuse venous hemorrhage from both of these ghastly wounds. Both of these openings allowed the free insertion of two fingers, so that having two fingers of each hand introduced it was easy for them to meet and to examine the whole internal extent of the injury. The lacerations were extreme in every direction. I at once gave a large dose of spts. frumenti, spts. ammon. aromat. and morph. sul.

I caused extension to be made gradually and firmly, while I brought the limb into its proper position, when four fingers were inserted to adjust the fragments as well as possible. Then applied a felt splint in front and back of the thigh, with openings over the lacerations: extension by crutch splint. During all the time of examination and dressing I kept up a constant irrigation with corros. sub. sol. 1 to 500, with acid carbol. 2 to 100.

Before placing the limb in a permanent position, the wounds were thoroughly washed with the mixture above named, with a syringe, and bleeding ceased at once: applied a thin layer of borated absorbent cotton over the wounds, over this a coating of collodion. As soon as the collodion had set applied a pretty thick coat of the cotton and a heavy coating of collodion, leaving a very small opening through the dressing at the most dependent points. The felt splints were arranged so that the antiseptic fluid would run from the external opening around the thigh to the posterior wound. Over the collodion dressing a thick bunch of cotton was applied, saturated with the corros. sub. and carbol. acid, this to be changed every day. Reaction came up before the dressing was completed. His temperature arose to 102 for thirty-six hours.

I did not disturb the dressing until the fifteenth day, when the posterior wound was found to have been oozing and emitting some disagreeable odor. When all the dressings were removed there was scarcely a perceptible scar to indicate the location of the external laceration, but the ham wound was discharging a little bloody serum, which had escaped in a small quantity into the husk pillow under the limb, thus causing the smell. Of this great wound a little sore the size of a nickel was all that was

left. The bones were uniting satisfactorily and the soft parts all adherent: no swelling or pain. There was not *one drop* of pus formed in the whole course of this case. Reapplied the dressing and occasionally readjusted the splints. On the seventh week put him on crutches with a good leg, one and a quarter inches short.

It seemed that the parts were totally or nearly paralyzed in a state of local anæsthesia, as examination, manipulation, extension and dressing caused but little distress. Dr. Warnock, our druggist, who stood by with chloroform ready to administer it when I should give the hint, was rather disappointed in not getting in *his* work.

I have used collodion dressings for all fresh cuts, scalds, burns, frost-bites, bruises, and varicose veins, ever since I assisted Prof. J. V. Z. Blaney in making it in his laboratory in the old Rush College in 1849, with better results than any other dressing I have ever tried. Germs cannot pass through the thinnest coating of collodion that can be applied, and nothing will disturb the dressing except sulph. ether. Try it!

Has the circuit court power to limit our charges in such cases as this to common visits?

This was a railroad accident. The boy had clung to the step of a box car while the engine was taking water, and rode about a quarter of a mile. In trying to jump off his limbs were dragged through a line of low posts at Nelson's elevator at the rate of twenty miles per hour. How he escaped alive no one can guess.

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## ANTE-PARTUM, HOUR-GLASS CONTRACTION OF UTERUS COMPLICATING LABOR—A CASE.

BY T. H. STETLER, M. D., PAW PAW, ILL.

Was called to attend Mrs. O. A. R. in confinement. Arrived at house 1 p.m., November 27, 1883. Married, aged 34 years: born in Norway, lived in this country about twenty years; short in stature, fleshy, quite intelligent. Was informed she had been in labor since 8 p.m. the day previous. Pains strong, about eight minutes apart. This was her seventh labor. Her first

labor was tedious, child dead when born. Four subsequent labors normal and easy. Two girls and two boys, all living. Her sixth labor was difficult and craniotomy was successfully resorted to. I could not obtain from patient or friends the nature of the complication necessitating craniotomy. This occurred three years previous to this, her seventh, labor. External palpation revealed a depression in uterine tumor just below the umbilicus. On digital examination found large roomy pelvis, os fully dilated, membranes ruptured, amniotic fluid slowly draining away, parts well lubricated; head at superior strait, vertex pointing to right side, cord prolapsed and feebly pulsating. My first efforts were directed to replace cord and get head to engage in superior strait and hold it there. In attempting to replace the cord with my left hand I found the uterus closely encircling the neck and shoulders of the child, and with each pain seemingly drawn tighter; a tense hard band, and no amount of force that I could exert enabled me to get my fingers past this constriction. Administered chloroform and reattempted to replace the cord; it would not relax at all; I failed. All this time pains were regular and strong. After one-half hour's hard work succeeded in applying and locking forceps, but no amount of steady traction that I could make would advance the head; with lateral movement and traction the forceps would slip. I tried extraction by forceps for nearly an hour and failed. Cord had long since ceased to pulsate and fœtus dead. Mother becoming exhausted I requested assistance be sent for, and in an hour Dr. York, of Lee, arrived. After informing him what I had done up to the time he arrived and a careful examination by him, we concluded to perform craniotomy, as for version no amount of force we might exert would enable us to pass the constriction. The Doctor administered chloroform, and after an hour's hard work I succeeded in extracting a ten-pound male child. Quite a severe post-partum hemorrhage set in. Carried hand up through constriction, and in upper segment of uterus on right side found detached and extracted placenta. Injected pure cider vinegar into uterus and with external compression controlled hemorrhage. Patient made a good recovery with suitable after-treatment.

There may be some objection to the title of this report by some. It is true it has no classical place in obstetric literature,



but that it does obtain and is a serious complication in labor, I am certainly convinced from my experience in this case. I have simply reported the facts in the case without minute detail.

Thomas C. Smith, M. D., Washington, D. C., has an able paper on this subject. See *American Journal of Obstetrics*, Vol. XV.

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## QUININE FOR CHILDREN.

BY W. M. LUCAS, M. D., FELICITY, OHIO.

Replying to the query by Dr. ——— of Wisconsin, in your November number, I would say that inunction is by far the best method of administering quinine to children. Mix the usual dose with a small amount of lard and rub it gently, but thoroughly, into the skin under the arms. I have employed this method almost exclusively for the last six years, with most satisfactory results.

While on this subject I will add, that in the summer of 1881, Zella G—, a child at nine months, came under my care, suffering with chronic peritonitis. During the progress of the disease I one day directed the mother to administer quinia 1 gr. by the above method. A very few minutes thereafter the little patient fell into a gentle, peaceful slumber which continued several hours. A dose of morphia could not have given greater freedom from pain, or more perfect rest. I continued the remedy daily with the same happy results until complete recovery. Who will explain or account for this effect produced by quinia?

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## ULCER OF THE FOOT.—A CASE.

BY S. F. MEACHAM, M. D., HUNTSVILLE, ILLINOIS.

A son of Mr. E., aged 16 years, called at my office with what appeared to be a superficial ulcer, located at the centre of the arch and half way between the centre and inner side of the foot. It had been there two years. No history of an injury of any kind; health good; inheritance good.

On close examination I discovered that the opening extend-

ed to the bone, being very small where it passed through the dense tissue of the foot, but one-half to three-quarters of an inch in size next to the bone. I suspected ulceration of bone, but wondered why it discharged through the bottom of the foot in preference to the soft tissue of the side.

On enlarging the superficial opening, it disclosed a fatty tumor of small size, which was something of a surprise to me, as it was too small to account for the trouble, besides it was suppurating but little. I removed the tumor and the dead tissue, and the wound healed nicely for a time and then became indolent. I applied a caustic hoping to secure healthy granulation. When the slough came away the end of a splinter extended into the opening from the side. I had failed to find it in cutting, because the tumor covered the end of it and because it was wholly without the opening, extending at right angles to it, instead of in the course of it as is usually the case. It was one inch long and nearly one-quarter of an inch wide: perfectly smooth, except at one end, which was jagged. It was at this end that the tumor was located, so that when I removed it, it left the membrane still covering the end of the stick.

The patient now remembers having hurt the foot four years ago, but as it healed readily and gave no trouble it was entirely forgotten. Two years elapsed from this time before the first trouble. The foot is now all right.

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## SOCIETY TRANSACTIONS.

### CHICAGO MEDICAL SOCIETY.

Stated Meeting, January 1886. President *pro tem.*, D. W. Graham, M. D., in the chair.

Dr. E. J. Doering read a paper entitled, "Mutual Protection against Blackmail."

The author stated that among the many trials which physicians have to encounter in the practice of their profession is the ever-existing liability of being black-mailed. This may either assume the more frequent form of a so-called malpractice suit, or the relatively less frequent charge of a criminal assault, accord-

ing to the viciousness of the complainant. Such suits against physicians are increasing. One reason quoted is the fact that every city is overrun with petty lawyers who have little or nothing to do, and are always willing to encourage any suit whatever, if there be the least prospect of getting something out of the defendant. The author stated that since investigating the matter he became convinced that many of these blackmail schemes were settled before being made public. Many a physician preferred being robbed of one or two hundred dollars, rather than incur the publicity, the loss of time and the endless expense of a lawsuit. Again, the average jury, composed of the ignorant and illiterate, will always have a strong leaning toward the complainant and against the defendant in a malpractice suit, as physicians are popularly supposed to be capitalists. The author stated that personally he had never been sued or even threatened with a suit, and it was therefore from no motive of selfish interest, but from a sincere regard for the welfare of the profession that he advocated the formation of an association for the mutual protection of physicians against blackmailing suits of all kinds. His plan is to organize a society composed of two or three hundred members of the regular profession, all of whom shall be of acknowledged ability, possessing a good moral character and standing in the community. Said association to employ the best legal talent attainable, by the year, to furnish the members such legal advice as they may desire at any time and defend any suit against the members arising in the discharge of their professional duties. It was stated that the expense to each member of an association composed of about two hundred would not exceed five dollars per annum, and that an initiation fee of five dollars would create a sufficient fund for court expenses. Such an association would be a power in preventing suits. Let it be known that the individual physician is backed by the financial and moral support of a few hundred of the best physicians, and aided by the best legal talent obtainable, and he will be let severely alone by the offscouring and dregs of society who constitute, almost without exception, the blackmailing element in our professional life. The author stated that he was not aware of the existence of such an association as the one proposed in any other city, but the principle at least had been carried out re-

cently by the New York County Medical Society, in voting \$500 to assist in the defense of the Drs. Purdy, members of the society, in the case of *Brown vs. Purdy*. After reading a number of letters from prominent physicians in favor of forming a protective association, and presenting several legal opinions sustaining the advisability, practicability and legal status of such a society, the author concluded by stating his firm belief that such an association for mutual protection was needed, that it would be a power for good, that it would draw the profession closer together, that, in short, it would be based on the principles of a common brotherhood, viz.: equality, harmony, justice and unity.

Dr. F. C. Hotz said that the extract of his letter to Dr. Doering, which was incorporated in the paper, indicated that at the time it was written he did not think favorably of the project. And, after listening with much interest to the doctor's arguments, he saw no reason for changing his opinion. Professional reputation and honor is the most personal of all personal property; if he lost it, it does not hurt anybody but himself, and therefore if any attack be made on it he should certainly wish to employ among the able lawyers the one in whose ability he had the greatest confidence. But he was not sure whether the lawyer retained by this protective union would be the one to whom he should like to trust the defense of his reputation. The attorney might be as able, or abler, than the lawyer of his own choice; but should the case go against him, he should never feel satisfied that the lawyer had done all that could be done for him unless he had full confidence in him. It is with the lawyer as with the physician, a question of confidence, and his patrons find no fault with his treatment as long as they have implicit faith in his ability.

An objection of greater weight, however, has been urged by several of the doctor's correspondents in asking what possible effect it might have if the fact was brought out in court that the defendant belonged to such a union? The lawyers whose opinions were obtained and read by the doctor say it cannot legally affect the case. There is no doubt but what this is true. But the verdict of a jury in malpractice suits is not determined by the legal aspect of the case; and circumstances which cannot have any legal effect upon the case have often made a deep im-



pression upon a jury and decided the case against the physician. To illustrate: In Dr. Bettman's first trial the experts of the prosecution testified so unreservedly in the Doctor's favor that had the case been submitted to the jury without arguments, the Doctor would have been acquitted at once. To fortify his cause Dr. Bettman's lawyer called a number of experts whose testimony was of course only cumulative. Now what did the prosecuting attorney do? Did he make an effort to break down the expert evidence by scientific argument? No, sir; but he wiped out its effect upon the jury by the mere waving of his hand, speaking thus: "The defense has piled up a mountain of expert evidence. But, gentlemen of the jury, what does it all amount to? These doctors are working together in the same hospital. Don't you see that they have a common interest to sustain each other, because every one of them may be in the same fix some day? Don't you know they are clannish? They won't admit that one of them can make a mistake. Oh, no!" One could fairly see the impression this harangue made upon the jury, and they rendered a verdict against the Doctor, though it is certain the lawyers will say the fact of his being associated with the experts in the same hospital should and could legally not prejudice the jury. But it evidently did, all the same. And after such experience, can you for one moment believe it would not damage the physician's cause if it was shown he and his experts belonged to a society formed for the express purpose of mutual assistance in malpractice suits. A mighty poor lawyer indeed he would be who could not make a great deal out of it before a jury.

Very interesting was that part of the paper in which the Doctor evolved his idea how this new society could prevent, ward off, malpractice suits. He believes the shysters would not be so eager to engage in this business if they knew they had to fight a corporation with plenty of means to employ the best legal talent. Why this should discourage those fellows, it is hard to understand. They do not sue poverty-stricken doctors. Whom they select for their victims they suppose to be rich and consequently able to employ a good lawyer. They do not expect to have all easy game; but why should they not try it? They don't risk anything by it. The blackmailer's stake is only \$2.50 for filing his application, and his lawyer's stake is his time,

which is not worth much anyhow. So you see, they have nothing to lose, but much to gain. What difference should it make to them whether the opposing counsel is engaged by one physician or by one hundred? If you wish to devise means by which this blackmailing nuisance can be stopped, or at least reduced to a minimum, you must try to get to the roots of the evil; that is, you must find the causes which usually bring it forth. And you will not go far to find them; for you find them at your door, in our own profession, in the shape of *indiscriminate dispensation of gratuitous services and of unkind remarks of one physician about another*. Physicians are altogether too quick to give their services gratis to almost anybody at any time. But you know very well people do not value very much what they can get for the mere asking; they do not think much of what they can get for nothing. And it is also a wide-spread notion (especially among the lower uneducated people) that the quality of the service is regulated by the amount of money they pay for it; that the treatment at a free dispensary, because gratuitous, is not the same, not as good as at the physician's office where they have to pay for it. These people cannot persuade themselves that a physician will take the same interest in a case whether or not he is paid for his services. The poor, therefore, are always suspicious that they do not get their full share of attention; they are quickly ready to charge their physician with carelessness if the case goes wrong. And with a patient in this frame of mind it takes but little encouragement to begin a suit for damages. And in nine out of ten cases, doubtless, this encouragement is furnished by the members of our own profession. He did not mean to charge physicians with purposely, wilfully instigating a lawsuit against a professional brother. Though this has been done, such extraordinary baseness is a rare exception.

What Dr. Hotz had reference to is the inconsiderate, careless, thoughtless habit of expressing an opinion about a case or a colleague. To illustrate: A physician at a dispensary shows a bad case to professional friends, and without thinking of the possible evil consequences, makes in the presence of the patient some remark like this: "Well, perhaps I ought to have done this or that." The patient already laboring under the impression that he was not fairly treated because he could not pay, he

sees in the doctor's remark the strongest confirmation of his suspicion, goes to a shyster and begging a suit for damages. And doubtless, in a similar way the mind of the patient is often poisoned and set against his physician by a careless or unkind remark of another physician. So many physicians are always ready to express their opinion about their colleagues in the presence of anybody, or to criticise their professional acts upon the information received from a patient or some old woman. Now you all know how these people misconstrue the words of a doctor; how they pervert the facts inadvertently. You must admit you cannot rely on what patients tell you, and you cannot form an opinion that is worth anything of a case you have not seen or been informed about by the attending physician. Why, then, don't you say so when some busybody asks you what you think about that case of Dr. H.? Or, if you know the physician, say he is competent to attend to his own business; if you don't know him, change the subject. But at all events, unless he be a notorious quack, refrain from uttering any words which even only insinuate the possibility of a mistake or want of skill of your colleague.

Stop running each other down; stand by each other; sustain each other, "stick together and be clanish;" let it be understood in public that no reputable physician will prostitute himself by going to court as expert for a blackmailer. If all reputable physicians of this city adopt and act on this principle, black-mailing the medical profession would soon be a thing of the past, and malpractice suits more effectually prevented than by the organization of a protective union.

Dr. P. S. Hayes said that from his costly experience in a malpractice suit he felt that an association such as suggested by Dr. Doering would be of great service. The lawyer employed by such an association would speedily acquire such a fund of medical knowledge that he would be considered an expert in malpractice cases. He would not require an amount of coaching necessary to prepare for any given case as would be requisite in the case of a lawyer who had had no experience in such cases. His opportunity for obtaining information in a given case would be largely extended, for each member of the association to whom he might apply would be interested in giving him the desired

knowledge. He would soon become acquainted with medical witnesses and know which would give the best testimony in any case.

An association of the character suggested by the paper might be a means of educating its members in regard to laws bearing on the rights of physicians and their patients, now not generally understood.

For one he is heartily in favor of such an association, and should give it his hearty support.

Dr. G. C. Paoli said Dr. Doering's paper is not only a valuable one, but contains such a high, noble, charitable feeling, that the society ought to be grateful to him. He wondered that such steps had not been taken before, because so many of our professional brethren have not only suffered annoyance, but pecuniary loss as well. How can we expect from an ignorant jury a decision based on scientific knowledge and justice?

Dr. F. M. Weller said that the subject of the paper was worthy of consideration; that the discussion of the formation of an association with an object so widely different from the medical society seemed out of place; the one essentially scientific, the other in the nature of an insurance. The right to form such an organization was unquestioned: the policy should be considered by each individual. That while any one might be made the object of blackmail, he believed that charges of malpractice more frequently arose from the ignorance of physicians of the statutes affecting the practice of medicine, especially those of the criminal code, and of the rulings of the courts in cases.

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## PERISCOPE AND ABSTRACT.

### THE ADMINISTRATION OF ANÆSTHETICS.

In concluding a very interesting and practical lecture on the above subject, delivered at the Philadelphia Hospital and published in the *College and Clinical Record*, Dr. W. J. Hearn, after speaking of the necessity of one giving his *undivided* attention to his duty, etc., continues as follows:

What are the signs of danger in anæsthesia from ether? Pallor and lividity indicate failing heart and respiration. It is



said that ether kills by paralysis of the respiration, but death does not always occur in that way. It may result from paralysis of the heart. Stertorous breathing is one sign of danger. The usual cause of death is an overdose of the anæsthetic. Chloroform acts differently. As small a quantity as eighteen minims of chloroform are said to have caused death.

I shall in this connection speak of the proper method of treatment under such circumstances. The patient is placed on the floor and the ether expelled from the lungs by pressing the sides. Artificial respiration should then be performed by carrying the arms outward and then bringing them down against the sides of the chest. This should be done regularly about eighteen times a minute. The tongue is to be drawn forward and the trachea and bronchi put on a straight line. If there should have been vomiting, and there is any suspicion of food lodged in the larynx, tracheotomy should be performed. Flagellations with a wet towel should also be practiced, in order to excite the vaso-motor nerves and cause the patient to gasp. In hospitals, a battery is usually accessible, and then the positive pole may be placed over the phrenic nerve, while the negative pole is placed over the epigastrium, and in this way contraction of the diaphragm be induced.

Occasionally spasm of the glottis occurs, the patient cannot get his breath and becomes cyanosed. The proper plan is to remove the ether until the patient has begun to breath properly, and then resume the anæsthetic.

A word as to the proper quantity of ether to order. If you are going simply to anæsthetize a patient in order to open an abscess or examine a fracture, four ounces should be ordered. If a more extensive operation is contemplated, eight ounces should be procured, and if a prolonged operation is expected, sixteen ounces may be needed. Whether you use ether or chloroform, it should be of the purest character. There is a form of chloroform which is very dangerous, and there is a washed chloroform, which is not so dangerous. You should get the best. I prefer Squibb's ether because it comes in cans hermetically sealed.

In preparing the patient for the operation, see that false teeth, pins and tobacco are removed, and that there is no constriction around the waist or neck; and in this do not trust to the patient's word, but see for yourself. Ladies will deny that their corsets are too tight, when it is evident that the functions of the diaphragm are interfered with.

If chloroform is to be administered, the patient should be absolutely recumbent. If ether is to be used, this is not so essential. Where there is opportunity for it, the patient should be

ordered to eat no solid food previous to the operation, for the anxiety connected with the operation will interfere with digestion. This caution is especially important in cases where there is difficulty in opening the mouth, as in ankylosis of the jaw, for if vomiting occurred, the patient would be liable to asphyxia. One or two deaths from this accident have been reported.

Inquiry should be made in regard to the man's habits, whether he is a drinking man or not. The heart and lungs should be examined. The evidence of weak heart would be a contra-indication to the use of chloroform. It is important that these organs should be examined, for if anything happens to the patient, and you are asked in court if you had examined the heart and lungs, you will be able to say that you have. The presence of cardiac or pulmonary disease is no contra-indication, but in valvular disease of the heart, the administration will be made more carefully. In capillary bronchitis, I should be chary about administering an anæsthetic, for the amount of mucus secreted may cause asphyxia. In congestion of the brain, if I used ether at all, I should do it very carefully.

Having the patient with an empty stomach, and all constricting clothing removed, and in a recumbent posture, the next thing is the inhaler. The usual inhaler is a towel formed into a cone, with a piece of waxed paper on the outside. Numerous forms of inhalers have been devised. Here is the arrangement of Dr. O. H. Allis, of this city. This answers very well. The temperature of the room should be about 70 degrees. Not too cold or the ether will not evaporate with sufficient rapidity. If it is too hot the room will be saturated with the vapor of ether.

Having placed the head in an easy, comfortable position, I lay a towel over the eyes to keep out the sight of surrounding objects. There should be no loud talking in the room. The patient should be assured that there is no danger. This is of especial importance in the case of nervous ladies. They are apt to be frightened, and a frightened patient never takes ether well. In fact, some deaths which have occurred shortly after the beginning of the anæsthesia have been attributed to fright. Some have died before a drop of the anæsthetic was administered. The patient is to be assured that there is no danger, and should be instructed as to the manner of breathing. He is to take a deep inspiration, and not expel the air too rapidly. This gives more time for absorption. The patient should be allowed to take several long breaths in this manner before the ether is administered. Dr. Bonwill claims that these inhalations produce a species of analgesia. I think that it does obtund the sensibility of the bronchial mucous membrane, and for that reason the ether is received more kindly, and is not as apt to produce coughing.

We next pour one or two drachms of ether on the towel, and hold it to the patient's face. Do not apply it close at first, for this alarms him: allow him to get some air. It is desirable to keep pouring a little ether constantly on the towel without removing it. For this purpose the bottle devised by Dr. John Roberts does very well; the tube may be inserted in the apex of the cone, and a few drops of ether poured on the towel every few minutes. When the patient begins to come under its influence, which will be in a few minutes, he may become excited and perhaps struggle a little. You can then pour half an ounce of ether on the towel at a time and hold it close to the face, and the patient is soon fully etherized.

This takes from eight to twenty minutes. The average is probably about twenty minutes. In old persons and in children it does not take so long, while in healthy adults it requires a longer time. The length of time, however, depends largely on the skill of the anæsthetizer.

Do not use a towel placed flat on the face. I do not see how a patient can get much ether in such a way. If he struggles, and the towel is held on the face, he becomes unconscious; but this is too a large extent dependent on asphyxia. A cone made in the way described holds a considerable amount of the ether vapor.

It is possible to induce anæsthesia very rapidly. I have rendered a patient unconscious in one minute by dipping a towel in hot water, wringing it out, and sprinkling over it an ounce or two of ether. Dr. Muller, of Germantown, has devised an apparatus for this purpose, in which the ether is vaporized by placing the bottle containing it in a bucket of warm water. The vapor is conducted to the patient through a tube and mask, provided with a stop-cock to regulate the flow of ether. He has etherized a patient in less than a minute. There is less danger from rapid anæsthesia with ether than with chloroform. With the latter agent it should never be attempted. One objection to rapid etherization is, that a patient who has taken it once cannot be induced to take it again. I think that it must be a little dangerous, for it does not give a chance to watch the patient, and properly avert any accidents that may arise. I think that the slow method is the safer.

Having gotten the patient under the influence of the anæsthetic, a drachm or two should occasionally be poured on the towel, so as to keep him under it, do not pour on a large quantity at once, and overwhelm the patient and stop the operation. Do not let him come out of the ether, for then he begins struggling. Pour on a small quantity, as I have said, every few minutes, and keep the patient gently asleep. You know that the



patient is asleep, from his snoring respiration and from the insensibility of the conjunctiva. The conjunctiva and the genital organs are the last to lose sensitiveness. If the ether is kept up for some time, the face becomes pale. If sick stomach supervenes, the face also becomes pale. Often in the beginning of the administration, the face will become pallid, from sick stomach, but if you are sure there is nothing in the stomach, vomiting may be prevented by pushing the ether. If, however, the patient has eaten a hearty meal, it is better to let him vomit.

During the administration of ether, the bronchial mucous membrane secretes a large quantity of mucus, which may be so large as to almost choke the patient. If this happens, turn the patient on his side, and with the end of a towel remove the mucus. If the mucus is not removed, it prevents the patient from inhaling the ether well. I was called to give ether in one case in which, in previous trials, the patient had secreted mucus so rapidly that he could not be etherized. I overcame the difficulty by administering a glass of whisky and some morphia half an hour before giving ether. Although there was a large quantity of mucus secreted, enough ether was inhaled to render him insensible. It has been said that some people cannot be anæsthetized. I have never seen such a person. I have been able to anæsthetize every one in whom I have tried to induce this condition, although some required more care than others. Never allow a patient to be under ether a moment longer than necessary. The condition of shock which it induces tends to retard recovery. Always operate the moment the patient is ready.

There are other ways of administering the ether than those which I have described. It may be administered by the rectum. Dr. Miller, of this city, read a paper before the County Medical Society describing four cases in which he had done this, it might be said, successfully. The ether is vaporized by being placed in water of a temperature of 120, and the vapor conducted through a tube to the rectum, which has previously been cleared by an injection. An æsthesia is produced in from six to eight minutes. The abdomen is so distended and there is such a sense of burning that this is scarcely a desirable method. It might be employed, possibly to advantage, in some operations about the mouth. The four cases which were reported by Dr. Miller are the only ones in this city in which this plan has been tried, as far as I know.

After the administration of ether, there is a certain amount of lowering of the body temperature. If the patient is cold and much depressed, the use of hot-water bottles will be of advantage. Or a spirit lamp with a tube ending under the bed clothing may be employed.



The sick stomach which often follows the administration of ether, is annoying. It is difficult to do much for its relief. The patient may rinse the mouth with hot water, and if he can swallow some of it and vomit, he will get rid of considerable ether. The following is sometimes of service:

R. Spirit. Chloroformi,	8 drops	
Aceti opii,	3 drops	
Mucilaginis acaciæ,		
Aquæ, aa	q. s.	M.

This may be repeated every two or three hours.

A sick stomach may often be prevented by administering a hypodermic of morphia before the patient comes out of the ether. It induces sleep until the effects of the ether have entirely passed off.

Before leaving the subject of ether, I wish to call attention to the fact that ether vapor is very inflammable. When operating at night, as you often will, see to it that the light is placed higher than the ether, for as the vapors of ether are heavier than air, it cannot then reach the light. In applying the actual cautery to the face when ether has been administered, all that is necessary to prevent the vapor from catching fire is to remove the cone and pass a fan a few times in front of the patient, thus diluting the vapor.

Mixed anæsthetics are unsafe, on account of the difference in their rate of evaporation, and one cannot judge of the quantity of ether that is being administered. I never use them.

What have I to say of chloroform? As far as this country is concerned, it is rarely used. I used it for a number of years and never had an accident with it, but I cannot recommend it to you unless you are taught how to use it. My instructor was the late Prof. Gross, who never had a death from chloroform. I have given it to children eight days old, and to people eighty years of age.

Although, in some cases, chloroform is better than ether, I cannot advise you to use it. If every hospital had a professional anæsthetizer, he would become proficient in its use. It is said that chloroform does not kill children easily. You should be as careful with children as with adults.

The most dangerous subject for the administration of chloroform is a strong, vigorous man, who, in his struggles, may draw in a large quantity of the vapor, spasm of the glottis take place, and he cannot expel it, and death may follow. Old and weakly people bear chloroform well. I think that there is really less shock from chloroform than from ether. Chloroform has caused many deaths, but it is still successfully used in many

country districts. It has been said by a distinguished author, that, "the man who persists in the use of chloroform in the face of all the evidence we have against it, is beyond the pale of argument." I rarely use chloroform, except occasionally in children and in some cases of bronchial irritation. I am not afraid to use it, but do not use it because ether answers as well in most cases and<sup>o</sup> is safer. But do not forget that deaths have occurred from ether: over sixty have been reported, and I am sure many more have occurred of which we shall never hear.

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## NOTES ON THE TREATMENT OF DIPHTHERIA, BY PROF. DA COSTA.

Diphtheria may continue in an individual for a long time, relapses occurring from self-infection. Treatment must be preventive and individual. In the first place the strictest isolation must be enforced: remove all unnecessary furniture, clothing and the like from the room: disinfect the sputa, linen and everything from the patient, and, if possible, remove the paper from the walls and wash with some disinfectant. Do not allow members of the family to come in contact with well children, for fear the former may convey the poison to the latter.

The individual treatment is both general and local. In the former, *alimentation* and *stimulation* are of the greatest importance, given, as in typhoid, every two or three hours, day and night. Alcohol is given to the point of tolerance. Begin with  $\frac{1}{2}$  dr. to 1 dr. of brandy every hour: increase till heart and pulse are improved. The amount a patient suffering with diphtheria can take is incredible: a child aged 2 years has been given a tablespoonful of brandy every hour, and 1 dr. is quite common. There is present a condition comparable to that found in snake poisoning. Begin the stimulus early.

As to *medicines*, one of the earliest and best treatments is by potassium chlorate, 1 dr. to  $1\frac{1}{2}$  dr. per diem, in divided doses, well diluted. Next to this, either alone or combined with it, is tinctura ferri chloridi, gtt. x every hour or two, for a child aged 10 years.

The rising treatment now is with calomel. It consists in giving large doses frequently, not minding the free movements from the bowels. Give one grain every hour till twelve doses have been taken, then the same amount every second hour. This has been often tried in the *laryngeal* form, in larger doses, and is of especial utility in this variety of the disease.

Corrosive sublimate, gr.  $\frac{1}{20}$  to  $\frac{1}{12}$  every hour, is a similar but hardly as effective treatment.

Jaborandi is a very new remedy in this trouble. The idea is that when the patient sweats well the membrane will loosen. As it is very depressing, it is not safe unless the patient is quite strong.

Locally, strong caustics have been abandoned. Cleansing, disinfecting gargles are the modern treatment. Carbolic acid, with borax and soda may be used. Thymol holds a high place, never weaker than ten grains to the ounce.

R.	Thymol,	1 dr.	
	Glycerini,	3 dr.	
	Aquæ,	1½ oz.	M.

Sig.—Gargle. Dilute if necessary.

Permanganate of potassium, a favorite with the English, equal parts of lime water and glycerine, or two parts of the former to one of the latter, are very useful and grateful. When the patient is old enough, these are best used in the form of spray. Equal parts of Monsel's solution and glycerine may be used when the redness and swelling are very great. Do not scrape the membrane.

The most prominent among the solvents for the membrane are lime, bromine and pepsine. Of lime, it is difficult to get enough. Bromine is too irritating. The remedy that has done best is a saturated solution of pepsine in the form of spray.

Lactic acid, jaborandi and numerous other agents which have been used for this purpose have some solvent power, but not enough.

*Complications or Varieties.*—For *nasal diphtheria*, in addition to the ordinary treatment, carried on, if anything, more actively, keep the posterior nares well washed out with—

R.	Sodii sulphitis,	3 dr.	
	Glycerini,	2 dr.	
	Aquæ,	q. s., ad.	4 oz. M.

Pepsine may prove yet more effective. This washes away the membrane, checks decomposition of the same and prevents blood-poisoning. Use with the post-nasal syringe.

In *laryngeal diphtheria*, besides the ordinary treatment, the best results have been obtained by having the patient breathe the fumes from slaking lime. Also an occasional emetic, while patient has sufficient strength, does good.

*Diphtheritic paralyses*, with good management, usually recover. The blood is always deteriorated and patient is anæmic.

Give iron, nourishing food, red wines, strychnine, for the paralysis, best hypodermatically, if patient is old enough.—*College and Clinical Record*.

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### INODOROUS IODOFORM.

To render iodoform inodorous, several methods are recommended. Thus, at different times, tincture of musk, one drop to each forty grains, or oil of thyme, with the addition of a little thymol.

Dr. Schenk claimed, in the *Pharm. Zeitung*, 1882, that if one hundred and fifty grains of iodoform were rubbed up with one grain of carbolic acid and two drops of oil of peppermint, the odor would be so masked that it would not appear again even on heating.

Dr. Catillon has recommended the addition of tonka bean fragments to the iodoform bottle. This imparts an odor of bitter almonds, which, however, is lost after a few days exposure to the air.

Dr. Andrews, of Staten Island, N. Y., says that cumarin, a derivative of the tonka bean, will completely cover the odor if added in the proportion of three grains to the drachm.

Balsam of Peru masks the odor in a measure.

Dr. Oppler claims that forty or fifty per cent. of well triturated, freshly-roasted coffee will absolutely deodorize it.

According to the *Lancet*, Dr. Gillette has recently found that one part of sulphate of quinine and three parts of charcoal to one hundred parts of iodoform effectually accomplishes this result.

Dr. Krieger (*N. Y. Med. Record*, January 2, 1886) makes use of the ethereal oil of sassafras, a few drops of which, he says, suffice to remove entirely the offensive odor, and substitute therefor an agreeable aroma. I have made trial of this method of disguising the odor, and so far as my observations have gone, it does so entirely. I have succeeded with the non-ethereal oil (two drops to the drachm) in completely substituting the odor of sassafras for that of iodoform.

Prof. Morrow, in his recent work ("Venereal Memoranda," New York, 1885), after referring to the various expedients which have been employed for masking the odor of the drug, says, (page 286), "I have found that oil of erigeron effectually disguises the odor for a time."

None of the odorless iodoforms have appeared to me to fully warrant their being so designated. Delicate olfactories will



detect the peculiar odor sooner or later, in spite of any combination with which I am familiar.

I have recently tried the admixture of charcoal and quinine, and fail to find that it covers the odor to any marked degree.

Again, none of these combinations can equal in efficacy the pure iodoform, and it may be possible that some substances which destroy the smell may at the same time take away its principal virtue, as is the case with colorless tincture of iodine, and it is quite probable that the bad results and ill-effects which have at times followed the use of iodoform have been due to its use in improper combinations. The solutions of iodoform in collodion appear to act well for a time, but as the ether evaporates the iodoform deposits in the bottle, the solution becomes darker in color, and loses to a great extent its characteristic odor, and does not produce the same effects as when fresh. A coat of the iodoform collodion whilst fresh has almost as strong an odor as the powdered drug.

The application of the collodion dressing is attended with some pain, and in the case of a large ulcer I have known it to be almost unbearable. To obviate this the sore or ulcer may be covered with pure powdered iodoform. This forms a comfortable and efficacious dressing. If now it is desired to cover the odor of the iodoform, several layers of plain flexile collodion is painted over the whole. This will be found to give better satisfaction to the patient, and better results than any application of so-called odorless iodoform.

I have had such a dressing stay on a large syphilitic ulcer of the leg twenty-two days in a patient who was forced to make a journey in which he could not well dress the ulcer daily. On his return I found that the ulcer was less than one-half the size when he started, the discharge being taken up by the absorbent cotton, which in this case I applied in a thick layer.

He was taking constitutional treatment at the same time.—  
*C. W. Allen in Four. Cutaneous and Venereal Diseases.*

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### ANGIOMA TREATED BY CARBOLIC ACID.

The plexiform angioma or cutaneous nevus which is formed by the anastomosing tortuous capillaries which may be fed by either arterial or venous blood or by both, is frequently an unsatisfactory form of tumor to treat. The milder forms, known as "mother's marks," which consist of simple congestion of the capillaries and appear as merely red marks of various shapes, and which are likened by the imagination to various definite

forms, can be removed by scarification or vaccination, or when they are slight, projecting tumors by the pressure and contraction obtained by repeated applications of collodion. But the larger angiomas which are frequently subjects of much apprehension on account of their rapid growth, must be treated either by ligature, or the external application of persulphate of iron, when sloughing occurs, or by hypodermic injections or the cautery. It is not every physician who has a galvano-cautery, and in place of this the common needle placed in a cork handle, heated in the alcohol flame and thrust into the substance of the growth will, when repeated a sufficient number of times, completely obliterate the tumor.

The old way of treating the larger forms of angiomas by the injection of four or five drops of the persulphate of iron, commonly known as Monsel's solution, is not entirely free from danger. Although great care is taken to compress all efferent vessels when the injection is made, yet occasionally an embolus, formed from a portion of the tissues effected by the iron solution, will escape, and getting into the circulation will cause death. Such a case it was my misfortune to see only a short time ago.

Recently, I have been led to use, with very gratifying results, the method which I have seen employed very extensively in the surgical clinic of Professor Moses Gunn, of Chicago, the injection of carbolic acid and glycerine. A solution of pure glycerine and carbolic acid (95 per cent), equal parts of each, is made, and at first but five minims are injected by the hypodermic syringe into the nevus. This injection should be made once every four days, increasing the injection gradually until fifteen minims are thrown into the tumor. When this larger amount is injected, the needle should be inserted near or at the margin of the tumor, and then the handle of the syringe should be depressed until the point of the needle is near the surface of the angioma. Now inject five minims; then partially withdraw the needle and changing the direction inject another five minims, and again this can be done in a third place, the needle having been inserted but once. The tissues can be seen to whiten under the corroding influence of the carbolic acid. By these injections there is no coagulum formed which may become an embolus, but an eschar is made, a shrinking of the tissues results and shortly from the inflammatory action developed, a shrinking and lessening of the tumor takes place.

Surely this method of injecting hypodermically the carbolic solution is the safest, surest and most simple operation that has yet been advanced, and the results obtained are excellent.—*Medical Review.*

## CHEESE POISON.

In *Public Health in Minnesota*, No. 10, is an article by Dr. J. H. Adair, of Owatonna, giving an account of eleven cases of cheese poisoning which recently occurred in that town. After detailing the symptoms produced, Dr. Adair sums up as follows:

The invasion began three hours after the ingestion of the poison, and the most marked feature was its *suddenness*. The ill-defined sensations of pain and nausea, which are the usual precursors of an attack of gastric irritation, were wanting in a majority of the cases, the attack being remarkable for its rapidity of onset, occurring without warning, and while the patients were engaged in their respective duties. In general, as stated above, the attacks occurred about three hours after the ingestion of the poisonous material, although in the last two cases mentioned, the time was double that of the others. The most prominent and constant symptom has been vomiting, more or less severe and continuous, and in some cases evidences of biliary matter were found in the ejected substances, while mucus of a frothy appearance was common.

As to the quality necessary to produce the above condition, there is some question. Some of the patients were positive that they had eaten only a piece one inch square, while others admit that the amount was larger. The most rational explanation of this seems to be that the noxious material is not diffused equally throughout the entire cheese-mass, but is present in different localities in different amounts. In support of this view may be mentioned the fact that in two of the cases the patients had eaten a larger amount than any of the other members of the family, and yet the only thing complained of was a slight degree of nausea, which only occurred several hours after the appearance of the attack in the other patients.

The diarrhœa, when occurring, has been crapulous in character, and in only one case did it precede vomiting. Its duration has generally been from one to two hours. Headache, frontal in variety, was prominent in two cases, and cramping pains in the upper and lower extremities, lasting but a moment or two, were noticed in one.

No variation in temperature was observed, nor was the pulse rate materially altered, save in two cases where the prostration was rather marked. In regard to the duration of the attack, the minimum time seems to have been two hours, and the maximum eight. In two cases a hot, burning pain was present in the throat and stomach, which continued after all the other symptoms had subsided, showing undoubtedly the irritant nature of the poison. Thirst was not marked except in one case, nor was the abdominal tenderness excessive.—*N. W. Lancet.*

## ADULTERATION OF IODOFORM.

Attention was recently called by the *Journal de Pharmacie et de Chimie*, to the adulteration of iodoform by picric acid, which is a cheaper drug, while possessing many properties in common with iodoform. Besides being a poison it is capable of exploding when triturated in a mortar. Its detection is easy. When suspected iodoform is shaken up in cold water, it imparts to the water a yellowish color. The addition of a little cyanide of potash to the filtered liquid produces no effect if the iodoform be pure. If picric acid be present, on the other hand, after ten minutes a brownish-red color appears, due to the formation of isopurpuric acid, and after a still further delay, a brownish-red precipitate of iosopurpurate of potash takes place.—*Ibid*.

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## REST AS A THERAPEUTIC AGENT.

Amongst other things on the above subject, Dr. Geo. Covert has the following to say:

Growth and repair are almost identical processes. As all animal organisms possess the power of growth within themselves, so do they likewise possess the power of repairing injuries, of making certain losses good, and, like growth, repair is facilitated by rest. The natural promptings are plainly discernable in the conduct of animals. They seek rest and immunity from disturbance in sickness and injury, while the healing processes are being carried on. All the resources of the animal economy are thus utilized in repair and recuperation. Doubtless if man would faithfully imitate his fellow animals in this respect, he would combat disease and renew his strength as successfully as they do. In fact it is estimated that of all cases of sickness, if the promptings of nature for complete rest were but fully met, ninety-five per cent would recover. The man who, according to the statement of his neighbors, whenever he was sick, "went to bed and grunted it out like a hog," followed faithfully the animal instinct—and *recovered every time*.

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## MOTH AND TAN.

Moth and tan marks may be removed from the face and hands by a mixture of equal parts of lactic acid and glycerin. Sour buttermilk has been a domestic remedy, in this connection, for many years. Its efficiency is due to the lactic acid contained by it.



# THE PEORIA MEDICAL MONTHLY.

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\*The Editor is not responsible for the statements or opinions of contributors.

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## EDITORIAL.

### THE MEDICAL CONGRESS.

The affairs of the International Congress of 1887 are about at a standstill. The new committee has issued the rules and preliminary organization, but every one seems to be waiting for the meeting of the American Medical Association at St. Louis, in May, to see what may turn up there. It is the unexpected that happens, so we will not hazard a prediction as to what turn affairs may take. It now seems, however, as if the force of the opposition to the new committee had been spent, and that from now on comparative peace will reign in medical circles.

The "code question" is rarely thought of—cocaine is no longer a novelty—cholera has not started up yet—so that the medical editor is generally hard up for topics of startling novelty.

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### HARD TIMES.

Many complaints are made on all sides of "hard times," and we know that times are hard, but just think a moment, some two or three hundred of you, if you complain of hard times, who only owe us two or three dollars, what must be our situation when we are called on to pay a printer's bill of from

five to six hundred dollars every ninety days! Please keep us in mind, and forward at once the few dollars you owe us, and our burden will be greatly lightened. It is a fact that we have frequently had to pay the printer from the proceeds of our practice and outside work, when we have had many hundred dollars due us on subscriptions *long over due*. Those who have not yet responded to our "renewal card" will please give us a boost.

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### QUESTIONS.

#### CAN RHEUMATIC INFLAMMATION CAUSE BLINDNESS?

The pension office decides in a case in this city that rheumatic inflammation cannot cause blindness. What is the opinion of the PEORIA MEDICAL MONTHLY? I have been of the opinion during my medical life that rheumatic ophthalmia was very common,—and analagous diseases, rheumatic corneitis, rheumatic iritis, etc. I should like to see answers from many of your readers to the foregoing question, as this is of deep interest to many.—*J. P. Walker, M. D. Mason City, Ill.*

Let us have the information Dr. Walker seeks, and plenty of it, in time for the next issue.—Ed.

#### WHERE ARE THE TRANSACTIONS?

Why have I not received my copy of the Transactions of the Illinois State Medical Society for 1885, or is it not yet published? Please answer and oblige.—*Dr. C.*

We believe the transactions will be mailed soon, as the usual nine months' gestation are passed, and in a month after delivery the fledgling should be strong enough to stand the journey by mail to Dr. C.'s office. If this answer is not definite enough we refer Dr. C. to Dr. S. J. Jones, Secretary, who promised the volume should be ready by August 15, 1885,—perhaps he meant 1886.

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### STATE SOCIETY WORK.

We would like very much to have this subject discussed in the MONTHLY, and would be pleased to hear from any who have plans to propose by which a larger attendance can be secured and more life and vigor infused into our yearly meetings. Let your communications be short and to the point, and we will give them a wide circulation.

## NOTES AND COMMENTS.

It is estimated that there are one hundred and twenty thousand doctors in the United States.

"Charlatanism," says Dr. Holmes, "always hobbles on two crutches—the tattle of women and the certificates of clergymen."

The *London Lancet* is according to the managers of the International Medical Congress a hearty support. Better than some leading journals of this country are doing.

Dr. Kelly writes the *Medical Record* that the passing of a sponge saturated with strong ether over an adhesive plaster will cause it to adhere firmly to the skin.—*Am. Lancet*.

The *Medical Record* of December 26 says that it is reported that the New York Past-Graduate Medical School will not receive women as matriculants after the present session.

"Are you having much practice now?" asked an old doctor of a new beginner. "Yes, sir; a great deal, thank you." "Ah, I am glad to hear it. In what line is your practice particularly?" "Well, sir, particularly in economy."

It is said that Henry Berg did not quarrel with the disciples of Jenner as long as they confined their practice to human beings, but when Pasteur began extending his experiments to animals, Mr. Berg became President of the Anti-Vaccination Society.

Jasper E. Sweet, who shot and killed Dr. Thomas Waugh in Chicago last September, and who was tried recently and convicted of manslaughter, was sentenced to two years in the penitentiary by Judge Shepard, the motion for a new trial being withdrawn.

If, in corresponding with advertisers, our readers would always mention this journal as the source of their inquiries and the medium which attracted their attention to the particular firm addressed they would greatly benefit us, and themselves as well. Bear this in mind.

It is said that there will be about 1,000 fewer medical graduates this year than in the past several years. Much of this

decrease is due to the hard times, but more perhaps to the efforts of the Illinois State Board of Health in raising the standard of medical education.

D. W. Treller, 1774, calls attention to the relation of beds to men's lives. "Man is engendered in bed, and there begets other men; he is born in bed, he sleeps and wakes in bed, there he dreams, meditates, enjoys divine pleasures, suffers agonies, and dies."—*American Lancet*.

The four youngsters of Newark, N. J., who were bitten by mad dogs and were sent to Paris to be treated by M. Pasteur have returned. One of the boys describing the distinguished scientist's method of inoculation says: "The ole hoss stabbed me eleven times with a pair of scissors."

Dr. Bartholdi, a Chicago physician, has been in the habit of secreting his small-pox patients. Of these five cases were stowed away in a room behind a saloon bar. It was natural, of course, for the doctor to endeavor to extend his practice, but the Board of Health objected to his standing in with a favorite undertaker. Little perquisites from that source belong exclusively to the board.—*Peoria Journal*.

An English judge strongly affirms that a medical man should not leave a woman in labor, except his life be in peril. That if he desires to abandon the case he must tell the friends to get another doctor, and remain with the patient until the doctor arrives. If he does otherwise than this, he will be responsible before the law for such injury as may happen to the woman for want of medical attendance.

M. Kergovatz, of Brest, France, has invented a galvanoplastic process which, he thinks, will preserve the human body indefinitely, by enclosing it in an air-tight coat of mail. The body is first covered with a conducting substance, such as plumbago, or it is bathed with a solution of nitrate of silver, which, after decomposition under the influence of sunlight, leaves a finely divided deposit of metallic silver. It is then placed in a bath of sulphate of copper and connected with several wires from a battery. The result is that the body is encased in a skin of copper, which prevents further change or chemical action.—*Exchange*.



At a meeting of the French Society of Medical Jurisprudence a case was reported of a child who had died—so stated the certificate—of strangulation, which had also caused a rupture of the heart; and the latter fact was confirmed by the autopsy. The father of the child was accused of having strangled it, and was placed under arrest. The court was not satisfied with the medical evidence, and summoned Professor Brouardel, who stated that the rupture of a healthy heart can never take place after strangulation. The professor then examined the heart, and found ulcerations and an aneurism in its wall. The father was at once acquitted.—*Exchange*.

One of the funniest stories we have seen lately is that related by the *Florida Medical Journal*. It says that when Dr. Bowling, a pioneer medical man in the South, began practice he settled in the wilds of Kentucky, where he sat in front of his cabin for six months without a call. At last he heard the clatter of a horse's hoofs, and a lank, barefooted Kentuckian appeared. "Are you a doctor?" he asked. "Yes, and a good one," said Dowling. "What's the matter with that 'ar foot?" the man inquired, placing his heel on the fence. The doctor examined it closely and replied: "That, sir, is erysipelas." "Ery-hell," the man said, "a bee stung me." The doctor moved to Nashville.

A specialist in throat troubles was called to treat a Boston lady who manifested so much interest in his surgical instruments that he explained their uses to her. "This laryngoscope," said he, is fitted with small mirrors and an electric light: the interior of your throat will be seen by me as clearly as the exterior; you would be surprised to know how far down we can see with an instrument of this kind." The operation over, the lady appeared somewhat agitated. "Poor girl," said her sister, who was present, "it must have been very painful." "Oh, no, not that, not that," whispered the Boston lady: "but just as he fixed his instrument in place I remembered that I had a hole in my stocking."

A painful discovery that I have made concerning the profession in America is that it embraces a certain number of men now practicing by means of forged medical degrees, professedly conferred by the University of Zurich. When the beadle an-

nounced, two years ago, the publication of a statistical report, covering the fifty years of the university's history, he was besieged with letters offering him sums of money for the insertion of names of men practicing in America, and a caller one day offered him a handful of bank notes and a heavy purse of gold in the name of a foreigner then practicing in New York State. These two facts taken together, the preposterous ease with which the degree M. D. may be obtained and the total want of efficient control of the medical profession by the State authorities doubtless explain in great measure the contemptuous manner in which European physicians speak of the brotherhood in America and the dubious light in which they regard American diplomas. Their view is not the result of wholesale prejudice, for such men as Gross and Knapp are appreciated in Germany perhaps more highly than in America, and American skill in the manipulations of operative surgery and the excellence of American surgical instruments are always fairly regarded.—*Zurich Cor. Philadelphia Times.*

Dr. Joseph Holt, president of the New Orleans Board of Health, is industriously presenting to Congress his proposition for a commission to visit Central and South America to examine into the yellow fever theories evolved by the physicians of those countries. Eminent physicians of Mexico and Brazil have discovered, as they believe, a system by which the terrors of yellow fever may be checked by inoculation, the same as Pasteur's system for rabies, or similar to the vaccination system to prevent small-pox. Dr. Holt is an enthusiastic believer in the probable truth of the theory, at least he thinks it of sufficient importance to be worth a careful study, for if it should prove true that by a system of inoculation epidemics of yellow fever may be avoided, the cost will be repaid a thousand fold. He proposes that a commission composed of several physicians be appointed by the President to go to Mexico and Brazil and make a study of the system. Blanchard, of Louisiana, introduced a measure in the House to this end, appropriating \$40,000 for the expenses of the undertaking. Dr. Holt has been before committees of the House and Senate explaining it, and the chances seem favorable for its passage.—*Exchange.*

The Austrian Minister of War has ordered compulsory vaccination with calf lymph for the whole of the Austrian army. The order will be carried out with all expedition.

A sanitary convention is to be held at Howell, Michigan, under the auspices of the State Board of Health, on Wednesday and Thursday, March 3d and 4th.

The 500th anniversary of the foundation of the Heidelberg University will be celebrated next August. The celebration will be held in a hall specially constructed for the occasion, capable of holding 5,000 persons.

The first official recognition of female medical practitioners has just been made by the Italian government. The recipient of this distinction is Signorina Terne, M. D., whom Queen Marguerita has appointed one of her physicians in ordinary.

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### THE LAW OF NEWSPAPERS.

1. Subscribers who do not give express notice to the contrary are considered as wishing to continue their subscription.

2. If subscribers order the discontinuance of their periodicals, the publisher may continue to send them until all arrearages have been paid.

3. If subscribers neglect or refuse to take their periodicals, they are held responsible until they have settled their bill and ordered a discontinuance.

4. If subscribers move to another place without informing the publisher, and the papers are sent to the former directory they are held responsible.

The courts have decided that refusing to take periodicals from the office or moving and leaving them uncalled for is prima facie evidence of fraud.

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I have much pleasure in bearing testimony to the remedial effects of Peacock's *Fucus Marina*. I am better pleased with its action than anything I have ever used as an antidote to malarial poisoning.

Respectfully,

J. T. HERNDON, M. D.

# THE PEORIA MEDICAL MONTHLY.

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## CLINICAL LECTURE.

### THE OBSTETRIC FORCEPS—COUGH IN PREGNANCY—PALPATION IN PREGNANCY.

BY PROFESSOR THEOPHILUS PARVIN, M. D., PHILADELPHIA, PA.

(Delivered at the Philadelphia Hospital, February 3, 1886.)

#### THE OBSTETRIC FORCEPS.

Some few days ago I was summoned to the hospital by my resident, to see a woman who was in labor. The child presented in the right occipito posterior position and the pains had ceased. The propriety of using the forceps was considered. The head was still high up, but the parietal protuberances were in the pelvis. When I was a student at the University of Pennsylvania, before most of you were born, Dr. Hodge was accustomed to teach that the head should be considered as engaged in the superior strait when the parietal protuberances had entered the inlet of the superior strait. When I reached the hospital, as is so often the case, the pains had returned and delivery was progressing as rapidly as could be expected under the circumstances of position. Now it is a somewhat difficult matter to apply the forceps to the head when it is high up and when the occiput is posterior, the manipulation of application will be apt to rotate the head posteriorly into the hollow of the sacrum; therefore in such cases it is better not to apply them. I left the woman, supposing that her labor would be completed in a few hours, but



alas for human anticipations, I found her still in labor the next afternoon. Now the foetal heart beat was 155 per minute and feeble and the pains were poor. Here, as sometimes will occur, nature had heeded the cries of distress that attested to the great suffering of the poor woman, and in response had stopped the pains. But the condition of the foetal heart and the evident exhaustion of the woman warned us that immediate delivery was imperatively demanded. Fortunately, spontaneous rotation had occurred and the occiput was anterior. The head was low down but not quite at the perineum. Sometimes this spontaneous anterior rotation will occur only as the head is about emerging from the vulva, but here it occurred high up. This rotation, I believe, occurs because the anterior portion of the head is more resistant. It would seem like heresy within the shadows of the University, to endeavor to explain the mechanism of rotation without enlisting the aid of the "inclined planes," so it was taught by Dr. Hodge, but I believe such an explanation to be erroneous, for I attribute it to the influence of leverage. If we take the frontal and occipital arms of the head level, we learn that the frontal are longer and possessed of greater power, so that they are held back, while the occipital, which are shorter and weaker, yield more readily to the expulsive influences.

To go back to our case; the child was delivered with forceps and the forceps was not removed as the head was escaping, as some authors teach, but was kept on until the head was fully delivered.

The forceps that I prefer is a slight modification of the Davis forceps, the modification consisting in a projection on each arm, which enables us to make traction, without undue compression. You have probably heard of the story of Emerson, who when traveling out west, found, one day, some pie before him on the table; he cut it and politely offered a piece to each person at the table, all of whom declined; placing a piece on his own plate he commenced to eat it, with the remark that he didn't know what pie was for unless it was to eat. So to apply the story to our own subject, I do not know what forceps handles are for unless to pull with. If you grasp the handles tightly, so as to make forcible traction, you are sure at the same time to exert compression to a considerable extent upon the foetal head, which

may prove a serious matter: you should only make just that amount of compression that is necessary to keep the forceps applied. Remember that the bi-parietal diameter is in relation to the transverse pelvic diameter, the latter of which is greater than the former, hence this diameter is the one that is least compressed by nature in a natural delivery. To press any more than is necessary to hold, is to produce injury. Besides, by this compression you are robbing Peter to Paul, for in so much as you lessen the bi-parietal, so do you increase the occipito-frontal diameter. The power exerted by pulling on the forceps has been carefully estimated and it has been ascertained that when we pull from the shoulders alone, we exert a force of eighty-eight pounds; when we brace the body against the bed, we can exert a force of one hundred and seventy-six pounds, and it has been computed that for every two pounds of traction force there is one pound of pressure. Thus, if we pull with a force of twenty pounds, we are compressing the head with a force of ten. This is a dangerous procedure and many children have died from this compression. This *is* Davis' forceps that I show you: please note that I say *is*, for some very distinguished authorities say *are*, which is erroneous and reminds me of the school-girl composition that "a cow *are* a useful animal." *Is* is correct for we are speaking of but a single instrument: no one would think of saying this *are* a saw, or this *are* a scalpel. Now I show you three Davis' forceps and you notice that they are all different: this one came from New York and the other two were made in this city. You will notice how clumsy this one is and how abrupt is the inferior curve. This is the one I use; you notice it is light and graceful, it only weighs ten and a half ounces and the inferior curve is gradual. Some men have made forceps sixteen inches long, not quite long enough for a walking stick, nor quite heavy enough for a club, but almost. Don't get these long, coarse instruments. This forceps, which is the kind used by the late Dr. Meigs, in his long and illustrious obstetrical experience in this city, weighing, as I have said, only ten and a half ounces, will prove adequate for nearly all emergencies. It will do for the high operation, save where the head is movable above the inlet of the superior strait, in which case, version is to be preferred to the forceps.

Now, as to taking the forceps off before the head is delivered: Dr. Goodell has told you, or if he has not, he surely will before he dies, to take them off. This was the teaching of Madame Lachapelle and of the German school long before her time, so that it is no new doctrine. Now, as much as I dislike to disagree with Dr. Goodell, I must say that I do not consider it necessary or even wise to remove the forceps in the great majority of cases. You will always gain instruction from the perusal of Dr. Hodge's work, and this great teacher tells us that the size of the head is not at all increased by the forceps, but I think myself that it is slightly increased. I can hardly conceive that a man's chest would not measure a trifle more when he had a shirt on than when he was naked: so with the foetal head; so that so far as the increase in size is concerned, Dr. Goodell and those who teach as he does are right, but the increase, I think, is very slight and as some time is consumed in unlocking and removing the forceps, nature may seize this period to expel the head, when you are not prepared for it and the perineum may thus be ruptured. Again, the head may stick, the pains vanish and a reapplication of the forceps be necessitated, which will prove a very difficult matter. Still further, by enabling you to regulate the time and manner of exit, the forceps may help you to prevent laceration of the perineum, therefore I think it is better to leave it in situ, unless you are using some of the huge forceps about which I have spoken. Those of you who were about in anti-bellum days will remember how universally the cry of "save the Union!" would be heard, and each time that congress met and each time that congress adjourned the "Union would be saved." Sincerely by some and sneeringly by others, this was the cry, "save the Union!" For centuries the cry among obstetricians has been "save the Perineum," but unlike the Union, the perineum has not yet been saved. Every little while we have some new plan suggested or some old one revived, for "perineum-savers" are relatively as numerous as once were "Union-savers." To protect the perineum there are two principles to guide us: First, to guide the direction of the head in its exit, and, second, to prevent it from coming too fast. I have recently read of a suggestion where the accoucheur sits on the right side and the woman is directed to slightly flex the lower

limbs, just enough to prevent putting the perineum on the stretch. One hand is placed under the near thigh and the labiæ on either side are seized by the thumb and fingers so as to approximate as it were, the perineum, now as the head emerges, the parts are drawn together and the perineum is saved. I can hardly place much reliance on this suggestion, though the author claims that having practiced it in fifty primiparæ, he has only had very slight and insignificant ruptures in but two cases. However, I think that the very position of the woman (on her back) favors rupture. Remember that statistics are very deceptive: it is said that figures cannot lie, but those of you who look at figures about election times know well that they do lie. However, if we take this author's claim with a grain, or even with a good many gallons of salt, the result is so good that it will be well to bear the procedure in mind.

#### COUGH IN PREGNANCY.

Here is a pregnant woman, who has had a cough for eight or nine weeks; there is not much expectoration, but she is losing flesh. Now you should always have your suspicions aroused when a pregnant woman loses flesh. The rule is that a woman will gain one-thirteenth of her weight during the last three months of pregnancy: if she loses weight, or even if she stands still or does not gain in this proportion, you can rest assured that something is wrong. The fœtus is dead, or perhaps she has pulmonary trouble. We have reason to fear that this woman has tuberculosis, though she has not yet been carefully examined for this condition. The constant cough causes pain in the uterus which will in some cases cause detachment of the placenta and premature labor, so that it is essential to stop the cough. For this purpose we will give this woman two or three drops of dilute hydrocyanic acid and one-sixteenth to one-twelfth of a grain of sulphate of morphia, in syrup. The older writers used to describe what they called rheumatism of the uterus, but I do not believe there is such a thing as true rheumatism of this organ, and I think that such cases were pain due to some traumatism, as the cough in this case. The sorrow of labor is from its exquisite suffering. A womb rendered sore from some tramatism will be exquisitely sensitive, just as would be a sore on the elbow, or any other part of the body where every motion



would cause great pain. So with such a uterus: every contraction will produce great suffering, and it may even cause irregular contractions of the uterus or arrest them entirely, for nature will heed the cry of suffering humanity and reply by putting a stop to the pains. So, therefore, it is important that this soreness should be attended to, and it can be best relieved by the wet pack, putting several thicknesses of muslin wrung out of water, over the abdomen at night, and covering all with a dry towel.

#### PALPATION IN PREGNANCY.

This woman I bring before you, has been confined several times. I bring her in to show you what we can do with palpation in pregnancy. Remember that palpation really means *touch*: we could palpate with the big toe, it merely means touch. You can stand on either side and before endeavoring to ascertain the condition of affairs you must first accustom the abdominal muscles to the touch of the hand. Now I feel a body, irregular in form, which is the uterine ovoid. Now, does the fœtal ovoid correspond to this? Yes. The next question is which end of the fœtus is below and which above? When you ascertain where the head is you can be pretty sure as to the position of the feet, but it is not enough to reason out the position of the pelvis from the location of the head: in mathematics you will prove all problems and so you should in obstetrical palpation. Now, I dip the fingers of each hand, one into each iliac fossa, way down and try to bring them together: something intervenes: what is it? Now in order to make the sensations conveyed to the brain more distinct, I will use only one hand, though I have been previously using two, for the impressions conveyed when only one office is telegraphing will be more distinct than when two offices are operating. Now, I feel a round, hard body very distinctly, low down, but I must not be too hasty in saying that this is the head; the head has a back below it (or rather above it, for the uterine fœtus stands on its head,) and I will look for it. There is a slight depression when the body is bent and then we pass on to the back. On one or the other side we will note a less distinct outline, which will indicate the anterior surface of the fœtus. Now, I here feel the back very distinctly on the right side. You know how a man "gets his back up" when he gets mad: well, I will make this fœtus get its "back up" by pressing on the two

ends of the fœtal ovoid. This proceeding will be very useful in doubtful cases. The next point is that if we find the pelvis above we will know that the head is below; but how are we to recognize this fœtal pelvis—how differentiate it from the head? It will be larger than the head, more irregular in outline and we can feel the lower extremities in its close proximity. The pelvis is also more movable. In primipara the head will descend a week or maybe a month before labor, owing to the resistance offered by the tense abnormal muscles; well then, you will find that when you press the fingers well down on either side, on one side they will go down deeply, which will be the side on which is the occiput, while on the other side their descent will be abruptly arrested by the forehead; this will aid you to diagnose position. If, now, I have interested you in abdominal auscultation and palpation in pregnancy, I have but taught you the alphabet of this important practice and you must go on and learn by diligent study, for it is one of the most valuable means of diagnosis. A distinguished French obstetrician once diagnosed triplets three weeks before labor by means of auscultation and palpation, and it is an achievement to be proud of. The prophet ranks above judges, kings and all other men. If you can make predictions that are subsequently verified, it will not only redound to your own personal benefit, but will serve to exalt your profession. A physician can not do any good act without its redounding to the benefit of us all. Remember that we all live, as Lord Bacon puts it, “for the glory of God and the good of man.”

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## ORIGINAL COMMUNICATIONS.

### BRONCHITIS IN CHILDREN.

BY O. J. ROSKOTEN, M. D., PEORIA, ILL.

Read before the Peoria Academy of Medicine, March 15, 1886.

Bronchitis is a bilateral catarrh or inflammation of the mucuous membrane of the bronchial tubes. In its commonest form it effects the larger bronchi only, being attended with moderate inflammation; a disease whose clinical history is such as not to require, in the opinion of most parents, the services of a

physician. There are the successive changes in the membrane with which you are familiar. The calibre of the tubes is so large that, in the absence of complications, moderate and even considerable tumefaction may be present without giving rise to any noticeable dyspnoea. If patients are old enough, they may complain of a sense of stuffiness in the chest, and of pain of a burning character: a raw sensation, referred to the position of the sternum. The moderate fever, with *repeated* chilly sensations, abates in a few days, when expectoration begins. The swelling of the mucous lining subsides, and mucus, at first glairy, then changing to a white or yellowish or even greenish color, covers it in patches. The irritative dry cough of the beginning is now replaced by the "loose" cough with expectoration of mucous in increasing quantity. There has been no appreciable obstacle to the entry of air; the masses of phlegm are relatively close to the larynx; the volume of air below or behind them is normal, and the accessory muscles of respiration have not been fatigued by excessive labor. Naturally, expulsion of mucus by coughing is easily accomplished, not attended with that difficulty requiring prolonged effort, which obtains in cases of bronchitis of the tubes of the third and fourth magnitude.

In a week or two, according to the severity of the attack, the amount of expectorated matter diminishes and finally ceases altogether, the cough commonly continuing, in a mild form, for a few weeks more.

This slight ailment is attended with but little fever and the symptomatic phenomena of the latter: the appetite returns in a few days and with it, apparently, good health.

When the inflammation, which has an unfortunate tendency to travel downwards, extends to the smaller air tubes, or invades them primarily, the case becomes more serious: dyspnoea is added, and all the symptoms become aggravated. The fever rises to 102 or 103 degrees. Breathing is accelerated and rendered more shallow, appetite nearly or quite lost and the case presents an appearance of considerable gravity. Aside from the greater constitutional disturbances resulting from the affection of a greater surface in inflammation, the dyspnoea and danger are in proportion to the mechanical obstruction which is occasioned by the swelling and by accumulation of viscid secretions.

The bronchial tube is not an inactive cylinder, but a tube endowed with contractility; this vital function is, in a measure, suspended while inflammatory tumefaction of the submucous tissues persists. The cilia, doubtless, in the swelled condition of the epithelial cells from which they spring, are also impaired in the exercise of their functions. Two factors in the propulsion of mucus are thus lost to the patient for the time. The calibre of the tubes being small, their lumen is readily nearly or quite occluded. Air enters the bronchioles and lobules beyond in lessened quantity, requiring greater respiratory labor. Expiration after accumulation of mucous is easier than inspiration, since the force which can be brought to bear against a mucous plug from behind, can displace it the short distance upwards into a larger tube, while the next inspiratory effort sucks the plug into the smaller branches farther than it was previously lodged, effectually closing it against the entrance of the tidal air. Thus the amount in the bronchioles and lobules becomes lessened (the inspiratory effort is expended in rarefying the air left in it); the natural contraction of the fibro-elastic structure of the lungs comes into play unbalanced and collapse of one or more lobules results, with or without subsequent inflammation. All these causes act with still greater potency when the bronchitis from the start is located in the smallest bronchioles, or has invaded them by extension from above. The disease, occurring in this situation has been aptly termed, "Suffocating Cartarrh," or Capillary Bronchitis. It is one of the most fatal diseases of infancy; fatal mainly, I insist, on account of its mechanical effects. The reason is manifest. The velocity and volume of the expiratory movements in the minute alveoli. Per contra: The power and volume of the inspiratory current in the trachea is distributed among the numberless small bronchi, until it arrives, almost exhausted by friction and division, at the bronchioles and lobules. Now imagine these small tubes blocked up by catarrhal swellings or by secretions! As explained above, the air can get out, but little in: mucous is sucked into and becomes lodged in the finest ramifications of the bronchial twigs just ahead of the infundibula — the site of the pulmonary function. This condition prevailing over the greater portion of both lungs, excludes from activity a very large though variable part of these organs.



Extremest dyspnoea suddenly develops on its advent, respiration becomes excessively labored: all accessory muscles of respiration are called into service, but despairingly only exhaust their strength: the breathing becomes more rapid, symptoms of stupor and coma from accumulation of carbonic acid develop: the previously flushed face and full pulse give place to deathly pallor and a feeble, flickering thready pulse, and the patient dies in asthenia or more rarely convulsions occur near the close of life. Could the swelling be overcome, or, later, the plugs expelled, for which there is no force adequate at the will of the child, life could often be preserved.

Thus far we have considered bronchitis as it is modified by its location: another division into varieties relates to the severity of the attack and its duration. It may be acute or chronic *ab initio*, or the one may be developed in the course of the other. As a rule, in robust children it is acute or subacute: its clinical history extending over from one to three or four weeks. After the attack has subsided, the mucous membrane is left in a state of irritability, which, on exposure, renders it liable to recurrence of the affection. The chronic form, which may continue for an indefinite period, is often primary, but more commonly results from an acute or subacute attack, as a consequence of repeated exacerbations in the course of convalescence, or of some cachectic state of the system, in which scrofula and rachitis play an important part. Like in the adult, chronic general or localized bronchitis is often dependent upon local disturbances of circulation in the lungs or upon congestion due to heart disease. As elsewhere in the system, chronic catarrh leads to changes in the mucous membrane as well as in the muscular and fibrous coats of the bronchi: such as thickening of the membrane, enlargement of the vessels, degeneration of the muscular fibres and development of fibrous tissue in the walls of the bronchi: by which their normal elasticity is impaired or destroyed. As a result of this weakening diffuse or sacculated dilatations develop, which again are productive of chronic inflammatory processes in the adjacent lung tissue. Ulceration may occur, suppuration be inaugurated, with disintegration of the parenchyma of the lungs in the neighborhood, and a cavity is formed. It would lead me too far to discuss the still more remote evils incident upon the

chronic bronchitis, such as implication of the bronchial glands: emphysema of the upper lobes from the long continued cough, and the changes in shape of the thorax produced in time by this affection.

The principal complications of bronchitis are pulmonary collapse and catarrhal pneumonia. The mode of production of collapse has been set forth above. It is generally limited to a few lobules in a cluster, or it may occur in different situations simultaneously.

The dependent position of the posterior portions of the lungs, to which the mucous, and the serous transudation gravitate, favor the production of collapse in this situation, as well as of catarrhal pneumonia. This fact is plainly shown by the frequency of these complications in foundling institutions, where ill nourished infants, which all day long are recumbent on their backs in the cribs, succumb to them by hundreds.

When a lobule collapses, congestion quickly follows, readily merged into inflammation. Lobules simply collapsed are restored by removal of the obstruction. In catarrhal pneumonia, which is the variety usually occurring under these circumstances, the alveoli cannot again, at least completely, be inflated. They are filled with a mass composed of serum and young cells derived mainly from those lining the alveoli by proliferation. Cell proliferation also takes place in the alveolar passages leading to the lobules; not however, in either situation in such abundance as to render the affected portions of the lung so solid as in the croupous variety of pneumonia. The latter, which occurs with increasing frequency after the third or fourth year, affects a lobe, or a portion of one, in its entirety, while areas implicated in even extensive catarrhal pneumonia present a number of lobules in a normal condition.

*Causes*—The cause of acute or subacute bronchitis is, in popular parlance, “taking cold.” This is brought about by a chilling of the whole surface of the body, or of some part of it. Rapid passage from warm to cold air, or vice versa, involving sudden differences in the temperature of the air respired, is another cause. Unknown atmospheric or telluric, in short epidemic influences, at long intervals exert a noxious power, the disease at such times sweeping across whole continents, and af-

fecting a large percentage of the population. Inhalation of irritating substances, such as dust, particles of metal, stone, as well as of irritating gases like chlorine, occasionally incite a bronchial inflammation, though these latter agencies more commonly affect the larynx only. Teething is considered by many an exciting cause, at least the fact of its frequent recurrence with catarrh of the bronchial as well as of the intestinal mucous membrane is adduced as evidence of such connection. I would rather consider the vulnerable condition as a whole of infants, at this critical period of their lives, as a predisposing, not as an exciting agent. At this point I may mention a debilitated state of the system generally, such as exists in scrofula or rickets, or in those poorly cared for, or after acute diseases, as favorable to the production of bronchitis. Anything that reduces the general tonus of the body is conducive to the same effect. Bronchitis is incidental to the eruptive diseases, and to pulmonic and cardiac lesions. In many cases we cannot satisfactorily trace a cause.

*Prognosis*—The prognosis in robust children is favorable, provided the disease is limited to the larger tubes. In debilitated subjects bronchitis is apt to become chronic. Extension to the minute bronchi renders the prognosis extremely unfavorable, especially when complications have arisen, which, it is to be borne in mind, may develop in cases originally ever so mild.

*Symptoms*—The symptoms of cases as ordinarily seen are so well known that I can confine myself to a discussion of those arising when catarrh extends to the capillary tubes. The breathing suddenly becomes rapid and labored, fine wheezing sounds are audible over the whole chest, especially at its lower posterior portions, followed by the subcrepitant rales, and mixed with the coarsest mucous rales seated in the larger bronchi. Fever arises: the countenance becomes anxious: patient restless: the epigastrium and lower ribs are drawn in with each inspiration; the supra-clavicular regions are depressed: the cervical and abdominal muscles participate in the respiratory efforts. Percussion still shows absence of fullness: violent but ineffectual coughing spells rack the patient, during which the cervical veins swell and the face becomes livid: the rales are not thereby much displaced, as there is too little air behind them: child has no leisure for eating or nursing. Despite these unfavorable symptoms the

prognoses is not necessarily fatal; as long as there is no evidence of carbonic acid poisoning, the case may yet recover. The vesicles get a sufficient amount air, though by dint of hard labor. Often, however, the respiratory muscles become exhausted, no longer adequate to the task of forcing air through the obstructions, breathing becomes more rapid and shallow, the pulse small and more frequent; drowsiness supervenes and the case soon passes beyond help. Collapse does not in these cases show additional symptoms; the dyspnoea is already extreme; pneumonitis renders the cough more painful, which can be appreciated on close watching. Both of these complications give rise to dullness, which, however, easily escapes recognition, since they are not apt to be very extensive. Moreover, bronchial breathing due to consolidation is drowned in the rattle of large and small mucous and whistling and wheesing sounds.

*Diagnosis*—An acute attack of bronchitis is ushered in with chilly sensations, repeated at intervals during its progress, mild fever succeeding. Pneumonitis, on the contrary, is preceded by a severe single chill, followed by more continuous and higher fever. Cough in all forms of bronchitis is painless unless complications exist. There is usually, however, a sense of soreness behind the sternum and soreness at the junction of the expiratory muscles with that bone, due to the violent and protracted coughing spells, which are loud and ringing, not suppressed and short as in the painful pleuritic and pneumonic inflammations. Ordinary mild or severe bronchitis limited to the larger tubes, is not attended with acceleration of respiration. Bronchitis, it must be remembered, may occur simultaneously with intercostal neuralgia or myalgia or abdominal affections which cause cough to be suppressed, thereby simulating the inflammations named. Percussion in bronchitis reveals normal resonance everywhere. Auscultation at first sibilant and sonorus, ronchi, succeeded by large and small moist rales when the secretive stage has arrived. An attack of cough changes the location of these mucous sounds. In capillary bronchitis finer, subcrepitant rales are heard, especially numerous at the base. These are conjoined with rapid breathing and corresponding changes in the pulse. The expiratory moan is absent unless pleurisy, pneumonia or the other affections above named co-exist.



*Treatment*—Commonly bronchitis requires little treatment. I am afraid that most physicians have dropped into a routine practice which is to be regretted. The prescription given is almost invariably a mixture of “solvents” and “expectorants to loosen the phlem” however loose that may already be. It may at times do no harm, if it does no good. I claim, however, that by this indiscriminate ordering of expectorants the lives of many infants are endangered if not sacrificed. If seen in its earliest congestive state a nauseant emetic, with restoration of the action of the skin, or the latter alone, may prove abortive of an attack. Failing in this, sthenic fever, if present, requires remedies calculated to diminish the force of the circulation, such as aconite, the antimonials, quina, ipecac. Veratrum viride is used, but in my opinion is too actively depressant. A warm bath, hot drinks and some mild aperient also tend to this effect. Among the laxatives calomel is very useful in small doses of  $\frac{1}{4}$  grain every two hours, though the *modus operandi* be unknown. Spirits of mildererus with spirits of nitre and jaborandi may be administered. If there be much useless cough a small dose of an opiate, or preferably, the extract of hyoscyamus or cherry laurel water, as not retarding secretion, should be added. Hot applications to the chest, such as mustard with linseed meal in the proportion of  $\frac{1}{2}$  oz. to 8 oz., or hops are useful as derivatives, and may be continued into the second stage. When the congestive stage has continued for a day or two, we must change our remedies to such as will promote secretion, (sooner than this we will hardly succeed) among these ipecac, squills, antimony, lobelia and especially the chloride of ammonium: also warm vapors impregnated with glycerine or lime. These remedies are useful as long as they are indicated by dryness of the mucous membrane, and should be stopped or lessened in quantity as soon as the cough has become quite loose. At the end of a week or ten days we may begin with stimulating expectorants to aid in the expulsion of mucus which is again becoming tenacious. Being now less abundant and more difficult to raise, it is thickened by evaporation into the air which is constantly passing over it as it is plastered against the sides of the air tubes. This class of expectorants has a tonic and stimulating effect on the mucous membrane, restoring it to its natural condition and increasing the

functional activity of the cilia and the bronchial walls. The most commonly used are squills, senega, the carbonate of ammonium, camphor and the resinous substances, such as benzoës and benzoic acid, tolu, Peruvian balsam, copaiba, cubebs. A small amount of a narcotic may be added if necessary. It is this combination of stimulants and expectorants with a little opium which renders paregoric so useful. Inhalation by spray or otherwise of tar or turpentine are also beneficial, especially in chronic cases. In cachectic children a tonic course with iron may advantageously follow the more direct medication. In capillary bronchitis or in ordinary bronchitis when there is a low state of vitality with debility arising early, we must withhold entirely the depressant remedies, using instead the stimulants freely. In these cases there often arises extreme danger from obstruction with mucous; the child is too feeble to now raise the phlegm in which it is drowning. To depress the system with arterial sedatives, to relieve the cough, to increase the amount of mucous by loosening expectorants is pernicious, is even murderous. By strenuous efforts the child gets air enough; enfeeble it by narcotics and the efforts are crippled; relieve the cough and the secretions settle still closer to the alveoli; loosen the phlegm and more accumulates. The thing to do is to evacuate the offending matter and this can only be done by a prompt and efficient emetic of zinc or copper. Ipecac is depressing; deaths have resulted from apomorphia. The improvement after thorough emesis is often next to wonderful. I now almost invariably begin the treatment in a child, especially in an infant, with vomiting (preceded by some stimulant) by which the air passages are well cleared. A large poultice applied over the whole chest, by virtue of heat and moisture, aids very materially in the improvement. The breathing after these two measures becomes deeper, less rapid and the infant once more finds leisure to nurse. At the same time we must by all means try to support the powers of life with stimulants and concentrated food, to enable the child to continue its laborious respiration for a few days, when the danger will usually be passed. The subsequent treatment is similar to that in ordinary bronchitis.

I once more would urge upon you the necessity of recognizing the mechanical nature of the danger; when this is appre-

ciated the proper course will suggest itself, and measures be avoided that would make matters worse.

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### IS THE BLOOD THE LIFE?

BY S. F. MEACHAM, M. D., HUNTSVILLE, ILL.

Having read so many articles lately containing statements to the effect that the blood is the life, and that it becomes vitalized in the lungs by receiving, or having formed in it there, what they call vital, or animal electricity, and noticing that they all claim that "there can be no doubt on the subject", I am going to give a few reasons why I think there can be doubts on both these heads, and in fact *on all assumptions* regarding life.

That life and mind are correspondences; that they result from the continuous adjustment of internal relations to external relations, but few biologists doubt. Life results first, and in the lowest forms is without consciousness, without its subjective side; but with these exceptions life may be said to present two phases—the one subjective, the other objective.

Subjective life is life as known to the organism itself, is life as we feel it. It is unnecessary to present evidence to show that life regarded from the subjective standpoint is different in each organism from that of all other organisms. That no two individuals live that possess the same kind and degree of sensation and motion is patent to all observers, to all thinkers.

Objective life is the sum total of action as manifested by any organism or portion thereof—the action of any substance that has powers, however imperfect, of irritability, motion, aeration, assimilation, and reproduction.

But life as we thus see it, as we study it with our senses, as we define it, can never be united in thought with life as felt. However perfectly we may define or describe those redistributions of matter and motion constituting life, we can never thus give an adequate idea of life as felt in ourselves; we cannot thus be led to see clearly that the observed motions and the known sensations are but different sides of the same thing. We have a great many reasons for thinking that they are the same, and many of us do assume them to be the same, but we do not know it. In the realm of the known they must ever remain dual.

A little thought on this subject and a little more candor will show any one that the expression, "There can be no doubt", is altogether inapplicable to this subject and is at the bottom of much of our ignorance of the laws of life and of correct methods of therapeutics.

The nearest approach to certainty that we can rationally hope to reach is a reasonable hypothesis — one that is in harmony with all the facts. Now I do not believe that the assumption that the blood is the life is one of this kind. I do not believe that it will cover the facts. If we have life where there is no blood and if we have reasons for thinking that the blood does not vitalize the tissues but that the reverse is nearer correct, then we have reasons for doubting whether the blood is the life or the source of life in any special sense.

A perfectly homogeneous liquid would not constitute blood. It must to a degree be heterogeneous, composite. When I speak of homogeneity, I mean from the standpoint of tissue. Tissue homogeneity does not negative molecular or microscopic heterogeneity. We know that many of the lower animals are without even that primary differentiation of outer and inner tissues that constitutes the very beginning of development, of heterogeneity. They are simply a colloidal mass. Yet they are alive. They are, it is true, acted on by crystalloids, dissolved in water, including oxygen. Of course a decomposition results, and this necessitates recombination or death; but the two processes include all there is of life. Within these masses as constituting part of them there is nothing worthy of the name of blood. If it is life it should be here. If the source of life it should precede all other tissue, which is plainly impossible if evolution is true, and does not in these cases at any rate, as it is not there at all. These small animals need no circulatory apparatus, no blood. Blood is to convey nourishment to, waste from, and assist in aerating the tissues. As these small masses are colloidal, hence permeable to a high degree, and as their necessary food and air are contained in the surrounding water, their permeability is all sufficient.

Second: Does the blood vitalize the tissue when it does exist?

We know that the protozoa have vital tissue without blood,



so that it is not essential, at least. That it should finally become necessary to life is not strange, but that it should become either life itself or the source of it in any special sense would certainly be wonderful. The complexity of this blood is quite different in different animals. From not existing at all to an almost homogenous fluid, up to the white blood of the cold-blooded vertebrates; between this and the blood of man there is all degrees of complexity, all degrees of life, just as we would expect if it resulted by the gradual differentiation of tissue the result of an ever perfecting adjustment to the ever active surroundings and as adaptations to changing surroundings. The nitrogenous material absorbed from stomach and intestines is acted on by the blood itself, by the lymphatic glands, by the liver, by every organ and tissue through which it passes. Its change into muscle, and nerve, and blood is not effected at any one point, but is assisted by every colloid molecule in the entire body. So the blood of no two portions of the body are exactly alike. There is all degrees of variation—from the impure of the right heart which comes from the glomeruli of the kidneys, the purest of the body. In its entire round it undergoes the following changes: precipitation of nourishment by the tissues, absorption of waste products, of carbonic acid gas, of oxygen, of dissolved food stuffs. In passing through the lungs it gets rid of its excess of carbonic acid and makes good its deficit of oxygen, at the same time undergoing a change of electric state; but the same changes are undergone in the skin, differing in degree only. That there is a vital electricity generated or added in the lung which constitutes life itself is without a single fact to rest on. The oxygen added is a destructive agent and furthers the processes of vitality by causing disintegration, and thus necessitating reintegration and in no other way known. These two processes are not only essential, but a due balance must be maintained between them. That electricity results from all chemical and physical changes of a destructive or frictional nature; that no two organs or tissues are in like electric states; that any change of this balance engenders currents, are all known facts.

In the body or out of it, alive or dead, makes no difference. Why then not be subject to the same laws in the body as out of it? Nothing wonderful in all this, nothing that explains the re-

alization of tissue and the making good of the waste. To say that oxygen is the chief agent in this is to disregard the well-known fact that nitrogen is the principal element of all colloid matter and that its neutrality is at the bottom of all the constructive phenomena of organisms. Electricity is a destructive agent, working molecular changes and thus setting free the motion evoked in the complex organic molecules, aiding by this force vital activity.

We are thus left without an explanation of the vitalization of the food stuffs, or the repair of tissue.

The organism as a whole makes good its losses by integrating matter from the surrounding media, the organs do the same and as the units of assimilation (let us call them physiological for want of a better name), as these units must be subject to the same laws, it follows that an explanation of the changes here covers all. Let me advance an idea of how it may take place.

Let us take a crystal with a broken point and put it in a solution containing the necessary elements which manifest no tendency to crystalize. The crystal will precipitate and utilize the dissolved elements and reproduce the broken point. If instead of the broken crystal we use an entire one, it will grow at the expense of the solution, maintaining unaltered its original shape. A wasted blood unit surrounded by the nutritive plasma is in a like situation save that the elements of the units are composite, and while the necessary elements are always present they are not always combined. Nitrogenous substances are known to work changes in surrounding compounds, to originate or increase chemical changes in elements, undergoing no marked change themselves; catalysis we call it, a name with no definite meaning however. By means of this power the above mentioned units work the necessary combinations and are then situated like the crystals, and by their mutual and polar attractions rebuild themselves and form new units at the same time for future use or for growth, as the case may be.

These units must not be regarded as cells, for we have already seen that life exists before cells do and these constructive units must be there and active. It is an intermediate state between the molecule and the cell, resulting from the compound

forces existing in each animal. These units must be supposed quite different in the extremes of the living world but as possessing great similarity in the individuals of each species. They are modified by individual experiences and these modifications are inheritable, for the infant receives of these units from each parent. They are very complex and extremely unstable, being overdrawn by the accumulated effects of either vibrations as in the eye. These units exist in all the organs and tissues and possess the catalytic power, polar and mutual attractions by which they produce and utilize the elements of their composition from the blood plasma or nutrient solution around them. They are colloid and acted upon by the solvent crystalloids as above instanced, as constituting the entirety of vital changes in kind.

If the above idea of a physical basis of life is correct, if what we individually experience as sensation and emotion are on the observed side but molecuator chance, change from that highly unstable state characterizing all colloid matter, to a more stable condition giving out the retained motion during the change: if this idea is correct, then of course the blood itself nor the electricity added or generated in the being is not life nor the source of it but both with many other changes result from vital action at large. I am going, however, to give a few additional reasons for not regarding electricity and the life forces as one thing. Electricity is about 16,000,000 times as fast as the nerve current, the one being 42 meters per second the other 280,000 miles per second. Heat assists nerve action but retards electricity or even destroys electric phenomena altogether. Electricity is a constant current: the nerve current is interrupted. Heat, light and magnetism, the other forces allied to electricity, are also constant and if nerve force was also allied why not follow the same law? Simple contact is all that is necessary for the passage of the electric current, but in a severed nerve molecular continuity must be restored ere the nerve force will pass the break, contact will not answer. Why these differences if the two forces are identical? I wish to repeat in conclusion that I do not believe that any description of what we see as life will enable us to unite in a clear conception subjective and objective existence: hence I regard it as our duty to assimilate so far as possible, living phenomena as studied by the senses, unto that widest redistribution

of matter and motion constituting evolution in general, and that we should guard ourselves carefully and accept only on proof and not simply because simple or popular any hypothesis to the contrary. Let us without prejudice weigh all the evidence available and withhold judgment till proof is forthcoming. There is no wider contrast between the ignorant and educated than this power of withholding judgment and maintaining modifiability of belief and excluding the "no doubt" expressions from questions that must ever be more or less in the mist. Why do I regard it as our duty to trace the harmony between the living evolution and the evolutionary process at large. Simply because we are less likely to err in tracing out the uniformities of given laws, than in trying to discover exceptions to them: for, so far, we have utterly failed in establishing a single special process with an individuality marking it off by sharp lines from other actions of nature. Why then attempt to separate by a narrow line living actions from that great body of changes that we are pleased to call dead? Let us be careful that our feelings of a distinct individuality do not prejudice our senses when we turn them loose as fact gatherers.

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## FRACTURE OF THE PENIS.

BY A. A. CONKLING, M. D., BELLEFLOWER, ILL.

I was called at midnight, November 1st, 1885, in haste, to attend Mr. W., a carpenter, aged 35, weight 215 pounds. The messenger would give no idea of the trouble I had to contend with. On entering the house I noticed a serio-comic expression on the countenance of all, especially the wife. In a room adjacent lay the patient with a beautiful picture of despair on his face. I questioned his condition. He said that a short time before, while in a doze or half sleep, he had an erection and in attempting to bend the organ down with his hand he said it suddenly broke with an audible sound. I found the following condition: The penis (*corpora cavernosa*) was fractured about midway in its length. In the upper and left two-thirds there was a decided separation of continuity with great extravasation of



blood which filled the skin to its utmost distention, with considerable discoloration.

With regard to the treatment I would say that it was new with me. I made a neat pasteboard splint, well padded, and applied it, turned the organ up against and a little to the left of the abdomen, held in place by a T bandage. There was but little pain, two slight attacks of priapism. The same treatment was continued. At the end of two months there was a hardened ridge at the seat of the fracture which gradually disappeared and at this time, March 1st, is hardly noticeable, and he now says it is just as useful a member as there is in the family although at one time he thought it would only do to stub around with.

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## ACETUM OR VINEGAR.

BY O. C. REYNOLDS, M. D., SEWARD, NEB.

(Read at the Meeting of the Seward County Medical Society, Seward, Neb., January 13, 1886.)

*Mr. President and Gentlemen.*—I wish to call your attention to the drug acetum or vinegar. Acetum is an impure dilute acetic acid prepared by fermentation. It is found in the cupboard of every household and its varied uses as a condiment in cooking are well known to all; and for the very reason that we are able to obtain this remedy so readily, and without loss of time in cases of emergencies, it becomes our duty to investigate its action as a medicinal agent.

Our authors on materia medica and therapeutics simply say that it is quite a favorite domestic application for bruises, headaches, sprains, gargle in throat troubles and largely diluted with water is valuable in sponging the body for the purpose of reducing high temperature. Taking what our therapeutists have to say on this subject as our guide (and we have no other unless we find out by experimenting) we at once say that the medicinal properties are so meagre that we have passed it by as being a safe and harmless remedy to be left in the hands of our mothers, aunts and grandmothers to swab, gargle and bathe with until they summon the aid of the physician. It remained with them until about ten years ago, when it was discovered that acetum was a valuable hæmostatic. In a great many instances it was preferred to our old ones for the following reasons:

*First*—Easy to obtain.

*Second*—Its action was prompt.

*Third*—Not so irritating and its use was never followed by sloughing, as we have seen from caustics and the various preparations of iron and other styptics.

When this was made known it spread through our medical journals like a prairie fire, and was tried for almost everything, as all new remedies; and now you scarcely see an item concerning its use.

I have used this valuable remedy for over five years, and it has stood the test so thoroughly that I shall continue to look upon it as one of our sheet-anchors in hæmorrhages of the uterus.

To verify the above statements that acetum is a valuable remedy for the purpose of checking hæmorrhages. I will report its action as seen by myself in two or three cases:

*Case I*—July, 1880, I was summoned by Mr. F. to hasten at once to his wife, whom he stated could not live long without aid. I found Mrs. F. flooding very profusely; the attending lady had her on her back, pillows from under head, the foot of the bed raised two inches, and was applying sheets wrung out of ice-water over her abdomen, all of which I sanctioned and told the attendant to continue. I made digital examination. Found the os contracted so that I could not insert my finger. Then I gave a small dose of fl. ex. ergot, after which I got the following history:

Was in the habit of having to go to bed at almost each monthly issue and remain quiet for a few days on account of the excessive flow. If by accident she should hurt herself enough to start the blood she would think nothing of the wound bleeding from one to twenty-four hours. In answer to the question if she was not pregnant, she replied, "Can not say, as I have never been regular. I look for my courses any time from three weeks. Mother of one child six years old; came very near dying from hæmorrhage at his birth."

I asked if she had passed any clots; her reply was, "A great many," and that the last was in the chamber. I at once proceeded to examine the clot, and in picking it to pieces found a

fœtus that was nearly formed, which was not over one-half inch in length.

As this decided what I had to deal with I set to work with the usual remedies to check the flowing (as I was enabled as before stated, to get inside of the womb) and for over twelve hours I tried the virtues of ergot, hamamelis, digitalis, lumbi acetate and opium internally, and I tamponed with cotton batten saturated with solution of tannic acid, but as I failed to get the flooding under control by these means, and as I saw my patient was almost pulseless and unable to speak above a whisper, I informed her husband that she would have to die for I thought I had done all that was in my power to do. At this moment it flashed into my mind that acetum was so highly recommended by the journals (and as it was the handiest remedy at my command), I resolved to give it a trial. I happened to have an ordinary bivalve speculum in my buggy and as I lacked a dresser I cut a twig from a cherry tree about one-half the size of a lead-pencil, around which I wrapped cotton batten. Armed as I was then with a speculum, cherry dresser and one-half cup of acetum, I went through the ordinary mode of making two thorough applications to the inside of the womb with the dresser saturated with the above mentioned remedy.

I only had to wait about ten minutes when I saw with great pleasure that the leak had been stopped. I waited patiently for one hour and as everything remained satisfactory I left capsules containing one grain each of quinine sul. and Dover's powder, fl. ex. ergot in doses of ten drops, each to be given every three hours alternate; also advised the use of liquor at short intervals until the patient had rallied enough to be comfortable without. The treatment was continued until the second day when I removed the placenta by aid of placental forceps, after which there was only the ordinary loss of blood, but from fear I made one application of acetum inside of womb; put patient upon drop doses of nux every four hours and 2-grain capsules of quinine three times a day. Patient made rapid recovery.

*Case II*—In the fall of 1884, Mrs. L. age 33 years, mother of a fine looking lad of some eight summers. This lady was a member of the fashion society known to our profession as the "Anti-Kid Society." The constitution and by-laws of this A. K.

society are about as follows: "It shall be considered a shame and a disgrace for a lady to become pregnant and that they must keep from bearing children even at a risk of their lives." Now this dear mother who would not harm her child, sharpens a lead-pencil, finds the mouth of the womb as best she could, then makes a drive upon the little helpless creature with the following results: Flowing commences quite free and after several days of flooding she becomes alarmed and tells her husband that from some unknown cause this flowing came on and that she desires a physician as soon as possible. I was called and listened very attentively to the patient take on over the accident which, according to her story, she would not have had to occur for anything. Upon making a thorough examination I found that the womb contained a foetus which was putrid and the odor at the bed-side could scarcely be tolerated and the loss of blood was great. I informed Mr. L. that she was in a very critical condition and sent him after a syringe and a disinfectant. In his absence Mrs. L. confessed to having used the pencil as above stated. I used our ordinary remedies for flooding and to contract the womb, but the womb was so inert that it failed to respond, and as the flowing continued after I had removed all I could of the foreign mass, I injected hot water containing carbohc acid, and as this failed I asked for acetum and I used four ounces in a quart of hot water which I let flow as I had the carbohc injection directly on the inside of the womb. I had not used over one-half of the acetum wash when the womb contracted down in good shape and the effect was lasting. She made a good recovery under the usual treatment for such cases, until the second time her menses appeared, when they lasted for two weeks; she came to my office twice and I applied locally to the womb hamamelis, and since then she has enjoyed the best of health and has not had any further trouble with her courses.

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## TUMOR OF THE BRAIN.

BY A. B. ANDERSON, M. D., PAWNEE CITY, NEB.

The following case, presenting some interesting points for observation and study, I desire to report to your journal. I shall ask you to accept or reject my diagnosis of tumor of the



brain from the symptoms given in the history of the case, as the friends saw fit not to allow an autopsy.

Some time in the latter part of June, 1885, Mr. G. was taken with pain, not acute, in the left side of the head, at first being confined almost entirely to the ear. In passing the house a few days afterward I was called in and examined the patient. I found some swelling of the walls of the auditory canal, with slightly increased secretion. The pain continued nearly all the time, but only in the after part of the night was it severe. I thought the symptoms indicated catarrhal inflammation of the ear, and prescribed warm water irrigation and anodynes. Was called again in a few days, as patient was no better and could not get sleep. The periodical nature of the attack at this time being more pronounced, the inflammatory less so. I concluded that I had malaria to meet as a cause, and prescribed full doses of quinia, and a mercurial to move the bowels. There was at this time no fever. Under this treatment the pain gradually subsided until the patient was so nearly free from it that it was thought unnecessary to continue the anti-periodic. In its stead I gave quinia, iron and arsenic. A period of immunity from pain lasting about ten days followed, when one day feeling well enough to take a walk went into the field where the men were at work. He had not been out long when the pain came on, quite severe this time; not confined to the ear but effecting the whole of the left side of the head. I was again called and again put him upon fair doses of quinia—5 gr. every three hours. This failed to stop the pain and opium was added to the powders, which relieved promptly and the patient got several nights sleep. However, as soon as the effect of the opiate was gone the pain again returned. Blisters to temple and mucha were used without results. Hypodermatic injections of atropia and morphia were resorted to with only temporary benefit. The pain area was now well defined, being abruptly terminated by a line drawn from the base of the nose to the middle of the occiput. The character of the pain at this time was still periodical, beginning about 3 o'clock in the morning, increasing in severity until about 12 m. and gradually wearing away during the afternoon. At this juncture, at the request of the family, Dr. E. B. Moore of Harlin, Iowa, was sent for to see the case with me.

Up to this time there had been no derangement of vision, no paralysis, nothing that pointed to brain lesion except the persistence of the pain. Dr. Moore shared with me the opinion that the probable cause was malaria and advised another trial of mercurials and quinia. The latter he advised to be given in the following manner: One grain of quinia with  $\frac{1}{4}$  gr. of capsicum every hour, beginning at midnight and continuing until midday. Milk punch was ordered as the patient could bear it, also arsenic three times a day. At this time the temperature was slightly elevated in the evening, with a subnormal temperature about 10 a.m. The treatment last mentioned was followed by a mitigation of the symptoms. Small doses of fl. ex. gelsemium—3 drops—being sufficient as an anodyne. In about a week the pain left this, the left side of the head, and the next day appeared in all its former severity in the right side. From the very first there was slow but progressive emaciation, although great attention was given to nourishment with stimulants. The pain continued in the right side of the head until three days before the end when it again was referred to the left. After the pain went over to the right side from the left, as above described, was the first symptom of double vision or paralysis. At this time there was ptosis of the right side which persisted to the end. Double vision also prevailed much of the time after this. Gelsemium and tinc. opium were used to control pain and procure sleep. Patient still had hopes of getting better, as he did not suffer so much, could sit in the rocking chair, and walk a few steps alone. On the 14th of October I was passing and called; found him sitting in the rocking chair, having just finished his dinner. Said he felt quite well for him; had eaten and relished a pretty good meal. A very short time afterward he asked to be put to bed, as his head was hurting him and on the left side. Before getting to bed he had a hard chill, high fever, followed with delirium which continued for two days, during which time patient gradually sank and at the close of the second day died.

This is the history in brief of this to me interesting, suggestive and instructive case. The presence of malaria as shown by the partial though transient relief obtained by anti-malarial treatment, the moving of the pain from the left to the

right side of the head and then back to the left again, the progressive emaciation until the thighs were scarcely larger than my arm, the termination in an acute attack of either meningeal or cerebral inflammation, are points interesting to study in this case. It is always to be regretted that the physician is not allowed in the most of these cases to verify and locate the disease by post mortem examination. This case also shows how varying the symptoms may be, even though the disease be organic. Further comment I leave for others.

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### TREATMENT OF FISTULA.

A number of weeks ago a lady about 30 years of age, unmarried, of a perhaps somewhat strumous habit, presented herself for advice in regard to a sore over the lower end of the backbone, which had existed for several years despite the various kinds of treatment to which it had been subjected. It had, she said, originated in the formation of a "boil", which was at the time lanced and its contents evacuated. Since that time, however, it had continued to gather and break at intervals of from one to two weeks.

On examination I found a fistulous tract, perhaps two inches or more in depth, directly over the lower end of the sacrum and closely hugging its spines. The surrounding parts, together with the tract itself, had become thickened and hardened, and presented an opening about a quarter of an inch in diameter. It was a source of great annoyance in many ways, and the woman had submitted to all sorts of treatment nearly, without relief, until she was completely discouraged. It had been injected with iodine, carbolic acid, etc., cut open, setoned, and what not, all without avail. I had had some experience in the use of iodoform in the destruction of the peculiar property of pyogenic membrane, and concluded before resorting to anything else to give it a trial in this case. I used a uterine suppository carrier which I had at command, filled it to the depth of about an inch at a time with iodoform, and after inserting to the bottom of the fistula, with the piston pushed the powder out, and repeated the process thus until the cavity was entirely filled with the powdered iodoform.

The result has thus far been all that I could possibly have expected. The fistulous opening has been closed now for several weeks, under the influence of several repetitions of the treatment, the tissues about the seat of the disease have become more healthy in appearance and feeling, and the soreness and tenderness have in the main subsided.

I detail the above case for the benefit of any who may have analogous conditions presented for treatment, and which have resisted other methods of management.—*M. D.*

## PERISCOPE AND ABSTRACT.

### CLIMATIC TREATMENT OF CONSUMPTION.

From an article by Dr. Glasgow in the *Cour. of Med.* we make the following extracts:

\* \* \* In the early stage of all forms phthisis prior to, or after the acute stage has passed, and in cases not complicated by inflammation of the mucous membrane, we find the greatest benefit from a residence in the higher altitudes. In certain cases this is productive of a permanent cure. \* \* \*

It is now well established that high altitudes aggravate the morbid conditions due to an excited, irritable nervous system, although conditions resulting from nervous exhaustion are improved. \* \* \*

Cases of consumption complicated with disease of the heart, whether organic or functional, invariably do badly in high altitudes: these, with cases of emphysema, must seek lower elevations. \* \* \*

### DANGERS OF COCAINE.

Dr. Shaw, in the *Courier of Medicine*, has an article upon the abuses of cocaine, from which we make the following extracts:

\* \* A short time after its use, hypodermically, cocaine produces decided exhilaration in a vast majority of cases, lasting as a rule but an hour or two; in a few the exhilarant effect is more slowly developed and it lasts longer; but in others, in fact a tolerably considerable number, almost instantaneous depression of a manifestly dangerous and alarming character, sometimes amounting to positive collapse with every evidence of impending death is suddenly produced by its introduction, even in minimum



doses. \* \* \* The continuous use of cocaine, either *per os* or hypodermically, *impairs the desire for food* and frequently leads to derangements of the gastro-intestinal tract. \* \* \* Some one recently wrote an article in one of our local daily papers on cocaine, under the caption "The Devil's Own Drug," and I heartily congratulate him on the selection of such a phrase whereby to designate this drug, so devilish in its influence upon man when used for its exhilarating properties. For once this charmer has charmed its victim, it undermines his physical and mental powers, his honor, honesty, conscience, veracity, faith, chastity, morality self respect, and respect of his fellow men for him. Cocaine proves an *ignis fatuus*, luring on its victims to almost certain irretrievable wreck and ruin.

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### THE INFLUENCE OF DIET ON CANCER.

Dr. H. Percy Dunn thus writes to the *British Medical Journal*:

That diet has some influence upon the production of cancer is now generally believed. Since Moore first drew attention to the matter, in 1865, whilst discussing the question of the increase of cancerous disease, confirmatory evidence—partly comparative, partly direct—has been produced by several observers. But, in the case of the human subject, an inquiry intended to elicit evidence upon this point is open to certain objections if it is simply limited to the statement of the habits of a person in the matter of eating. For, undeniably, a "large eater" and a "small eater" are only relative terms. Women are universally small eaters; and, whilst full-bloodedness amongst them is quite the exception, they do not generally exhibit an underfed condition. Ladies, as is well known, are averse to eating much, because they are averse to placing themselves in a position of imperiling their "figures," by growing stout. In the case of men, a different state of things prevails. Men often eat largely without necessarily manifesting any trace of their eating habits. Their business occupations enable them to throw off any ulterior effects which full living might be supposed to induce. Consequently, although eating largely; they cannot be said either to eat to excess or to suffer from the food they consume. But a small-eating woman, by leading a life of ease and indolence, might suffer as much from the penalty of good living as a man who ate to excess. Still, inasmuch as it is impossible to assert that food and feeding occupies more than a subordinate position in the category of mundane attractions made accessible for women by nature, it is conceivable that diet has less opportunity of influencing the production of cancer in women

than in men. Now, if the terms "large eater" and "small eater" are only relative, as they obviously must be, how can the question of diet in this relation be determined? By using the term plethoric, which is descriptive of a condition exhibited or not by the patient at the time of the examination. If plethoric, then the diet, whatever its nature, has been in excess of the nation's requirements. If not plethoric, the patient could scarcely be accused of free living, even although the presumption would be in this direction, when further inquiry elicited the fact that good living was the rule.

There is little known as yet of the connection between diet and cancer; but, as a matter of opinion, I am disposed to believe that the influence of diet upon cancerous disease is chiefly centred about those persons whose practice throughout life has been to live freely, whose plethora has always been a positive quantity, and whose cancer becomes developed in one of those organs immediately concerned in actively disposing of the surcharge of food injected.—*Reporter*.

## LACTIC ACID AS A DESTROYER OF PATHOGENIC TISSUES.

Since Mosetig-Moorhof's favorable results with this agent (*Centbl. f. Chirg.*, 1885, No. 12) various other observers have made use of it, in lupus, superficial epithelioma, papillomatous growths, fungous processes, scrofulous ulcerations, laryngeal phthisis, etc. Its advocates claim that it is not a true caustic, but selects deceased and spares healthy tissues. Wherever its application is practicable it is consequently to be preferred to curetting.

The acid is a syrupy liquid miscible with water. Though not considered necessary by some, its action may be confined by covering surrounding parts with plasters, collodion or traumaticini; fats are an impediment. It is applied on linen, felt, or the like, either pure or reduced with water, or mixed as a paste with a pure pulverized silicic acid. It may be applied with a brush, but does not then act as rapidly. It is further recommended to bind it on with rubber, paper, or other confining material. It causes considerable pain for a few hours (Bum says 1-3) and is usually removed in twenty-four or less.

Joseph (*Deut. Med. Woch.*, 1885, No. 43) cured a leucoplakia buccalis with 80% diluted lactic acid. Schnitzler reported at the September *Naturforscher-Versammlung* his experience with it—not very favorable—in tuberculosis of the larynx.

Krause, of Berlin, has also used it in this affection, and Jellinek (*Wien. Med. Wochenschrift*, 1885, No. 46), in Schrotter's clinic, has for some months given it a more thorough trial. For this purpose he prefers a 20 to 30% solution. The healthy mucous membrane is but slightly affected, while infiltrated portions are slowly destroyed. The more succulent the infiltration, the more vigorous the action: œdematous parts shrink in three or four days, and troubles in deglutition are rapidly relieved. Most favorably affected were small ulcerations, especially on the vocal cords; larger sores were only prevented from further growth. In ulcerous, granular and hypertrophic pharyngitis he had good results. In nasal troubles simple brushing does not suffice; longer contact is necessary. Jellinek believes that in laryngeal phthisis by daily application more can be accomplished with this than with any other remedy, and that in its earlier stages it can be cured.

Bum (*Wien. Med. Wochenschrift*, 1885, No. 47) has for several months been employing it in fungous, *i. e.*, tubercular disease of soft parts—skin, subcutaneous tissue, lymphatic glands—in dispensary practice. The unhealthy granulations are reduced to an easily reducible pulp; the walls of the cavity do not bleed; after two or three applications, with intermediary pauses of two days, a permanent dressing of iodoform gauze is used, abundant healthy granulations develop, and a smooth, soft scar results. Lactic acid will attack healthy as well as unhealthy epidermis, but in the subdermal tissues it seeks out fungous nests and destroys them. Bum gives the histories of nineteen cases in patients from 1 to 52 years of age. There were eight males and eleven females; eight ulcers, seven fungous and four fistulous. The average number of acid dressings was three, and the average time of cure twenty-five days, or, deducting one who removed dressings, but nineteen and eight-tenths days. No failures, and up to date, six weeks to five months later, no relapse.

Finally Mosetig has returned to the subject again (*Wien. Med. Wochenschrift*, 1885, No. 48), with the demonstration of good results in a large facial epithelioma in a man aged 55, and an *ulcus rodens* on the face of a woman aged 60. In the former he had made twenty-six applications in a month, and in the latter he had made twenty already. In caries he finds it excellent, good demarcation being produced, and there being less liability to relapse than after curetting. He has tried injections of the acid,  $\frac{1}{2}$  to 1 grm. of a 50 to 70% solution. Whether relapses may yet occur he, of course, cannot say.—*Annals of Surgery*.



## ON THE ACTION AND ELIMINATION OF IODIDES.

The high repute which iodine and its preparations have enjoyed ever since the introduction of this metal into therapeutics by Curtius at the beginning of this century, rests almost exclusively upon an empirical basis. The physiological and experimental researches instituted with these drugs have hitherto shed but a dim and scanty light on the actual mode and nature of their efficacy. It is almost easier and shorter at the present day to enumerate the maladies in which iodine and its preparations are not ordered than those in which they are employed. This state of affairs is aptly illustrated by the well-known bon-mot appearing in the text-book of Nothnagel-Rossbach: "When the physician is at a loss what to do, he prescribes the iodide of potassium." Only a year or so ago the medical world received with surprise the authentic report of an entirely new pathological field for the curative power of iodide of potassium (*Progres Medical*, October, 4, 1884), Prof. Fournier, of Lille, publishing a case of genuine tubercular lupus which was cured solely by this drug.

Still, in spite of the uncertainty and even confusion which exists in our knowledge of the therapeutic virtues of the iodides, clinical experience has well established their high value in a number of morbid processes, among which deserve to be especially mentioned syphilis, hypertrophy of the thyroid body, scrofulosis, gout, alterations of the aorta and great vessels, asthma, chronic bronchitis, and albuminuria.

If, however, experience has taught us numerous indications for the employment of iodides, it has given us no insight into their *modus operandi*; we are, in one word, very rich in empirical facts, but very poor in rational notions as to these important remedies.

Regarded by some therapeutists as moderating agents of nutrition, by others as stimulants of the same, the iodides have in turn been accused of creating obesity and reducing it, of augmenting diuresis and diminishing it, of increasing the elimination of urea and decreasing it again. This conflict of contradictory opinions compels us to appreciate the thorough and strictly scientific study of Dr. Dugene-Louis Duchesne (Paris, Inaugural Essay 1885) on the action and elimination of iodides, which we hereby present in its essential features to the readers of the *Therapeutic Gazette*.

## I. ACTION OF IODIDES ON DIURESIS.

*Iodide of Potassium* was administered in fifteen cases in doses varying from  $7\frac{1}{2}$  to 75 grains, and for a period of two to thirteen days, and gave the following results: In seven cases the



urine was noticed to be increased slightly (2 to 8 ozs.), and in one case greatly (30 to 34 ozs.) In seven cases a slight diminution of the urine was observed during the period of the administration of the drug (2 to 7 ozs.) These variations move between such restrained limits and show such direct oppositions, that we are forced to assume that they are wholly independent of the influence of the drug.

*Iodide of Sodium.*—This drug was administered in one case in doses of cases of 60 grains *pro die* for a period of nine days, with the following results: The urine increased 2 ozs. during the period of administration; in another case, where 30 grains were given for six days, a diminution of 22 ozs. was observed. During six days following upon the cessation of the drug, the diminution of urine amounted to one quart. It is hard to draw any definite conclusions from these contradictory observations.

*Iodide of Calcium.*—In two cases where this drug was administered in daily doses of 30 and 60 grains respectively for a period of six days, a diminution of 5 to 6 ozs. during the period of administration and during the following period was noted. We know, then, that the iodide of calcium does not increase urination, but rather appears to diminish it.

*Iodide of Ammonium.*—This drug administered in doses of 45 grains daily for six days, produced an augmentation of 4 ounces of the urine for the first three days of administration. During the fifteen days following upon the cessation of the drug, this diminution amounted to 14 ounces. In another case, where 15 grains was given for nine days, an increase of 24 ounces during the first four days, and a diminution of  $5\frac{1}{2}$  ounces during the five last days, was noticed. During the five days following upon the cessation of the drug the diminution amounted to 8 ounces.

These two results go to show that iodide of ammonium augments slightly diuresis during the first few days of its administration, and decreases it later.

*Polyiodides* (KI, NaI, CaI,  $\text{NH}_4\text{I}$ ).—In one case where the polyiodides were given for five days in equal and progressive doses of 15 to 75 grains, the urine decreased 20 ounces during the period of administration, and increased 4 ounces during the following five days. In a second similar case a diminution of  $3\frac{1}{2}$  ounces during the period of administration, and an increase of 39 ounces during eight following days, took place.

The combination of iodides appears thus to act inversely as the iodides alone—viz., to diminish diuresis at the end of the administration of the drug, and to increase it during the days following upon the cessation of the drug.

*Tincture of Iodine.*—In five cases where the tincture of io-

dine was exhibited in progressive doses of 8 to 28 drops for a period of five to fourteen days, the urine increased in every case (excepting one)  $4\frac{1}{2}$  to 6 ounces during the period of administration. In the six days following in all cases (excepting two) a diminution of 10 to 28 ounces was observed. Hence we learn that the tincture of iodine increases urination at first, and then after cessation of the drug leads to a diminution of the urinary quantity.

## II. ACTION OF IODIDES ON UREA.

*Iodide of Potassium.*—Under the influence of this drug urea was found to increase. This increase persisted, and even grew during ten or fifteen days following upon the cessation of the drug. These variations, though, are not great, from 30 to 45 grains usually; they never exceed 120 grains: in one case only the enormous figure of 210 grains was reached. The dose, the mode of administration, and its duration, did not influence in any way these variations.

*Iodide of Sodium.*—This drug given in a comparatively large dose (60 grains) produced a temporary increase of urea, which was soon followed by a notable decrease, lasting for several weeks after the cessation of the drug, and amounting to the enormous figure of 50 per cent.

*Iodide of Calcium* lowered quite appreciably the figure of the uric excretion even for a period of two weeks after the cessation of the drug.

*Iodide of Ammonium* raised the secretion of urea at the end of the administration of the drug, and lowered it during the following eight or ten days.

Polyiodides were found to decrease the excretion of urea during their administration and during the following three days. His conclusion as to the effect of the tincture of iodine was that the latter had a varying effect upon nutrition as to the exhibited dose; in a dose of 16 drops and exhibited for a period of about a week, the tincture was found to exert a decidedly favorable effect upon the general nutrition. If, however, this dose be exceeded and the period of administration prolonged, the reverse condition—viz., a notable depression of nutrition—took place.

*Action of Iodides on Uric Acid.*—The iodides of potassium and calcium were found to slightly increase the excretion of uric acid.

The iodide of ammonium produced a considerable augmentation of the uric acid excretion, while the polyiodides lowered the same.

At the conclusion of his study Dr. Duchesne arrives at numerous interesting results as to the action of the iodides on

on nutrition and their mode of elimination, which we shall briefly refer to.

The iodides have but a slight action on diuresis.

Their influence is marked by a slight increase of the urinary excretion during the period of administration of the drug, and at times during the first few days of this period only. The increase is soon followed by a decrease, which persists for ten to fourteen days after discontinuance of the drug. Among the salts of iodine, the iodide of potassium showed the feeblest action in this respect.

The iodide of ammonium and the tincture of iodine act alike on the urinary excretion, increasing it during the period of administration, and reducing it immediately after cessation of the drugs.

The elimination of nitrogenous matters (urea and uric acid) is modified by both the salts and the tincture of iodine, though the various preparations do not act alike. Iodide of potassium augments the uric excretion during the following ten to fourteen days. This augmentation, which is always 30 to 45 grains daily, may amount to 105 to 120 grains (exceptionally to 225 grains). The tincture of iodine acts as the iodide of potassium, but more energetically.

All the preparations of iodine favor likewise the elimination of uric acid during and after the administration. Their association, however, and the tincture produce the opposite result. During and after their administration the uric acid elimination is decreased.

These observations show the impossibility of considering the iodides *en masse* either as stimulants or depressants of nutrition, as some favor the elimination of nitrogenous matters, as the tincture of iodine and the iodide of potassium, and others retard this elimination, as the iodides of sodium and calcium.

Therapeutically, we infer from these facts that, wherever an energetic action upon nutrition is intended by intensifying the process of nitrogenous elimination, the potash combinations, or still better the metallic salt, recommend themselves. Such indications would arise in all maladies attended by a weakened nutrition, such as stone in the bladder, gout, rheumatism, and others.—*Therapeutic Gazette*.

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## THE ART OF PRIMARY UNION, OR UNION BY [ ] ADHESION IN LARGE INCISED WOUNDS.

[ ] The purpose of this paper is to combat the theory of the value of antiseptics in wound treatment, and the name of its dis-



tinguished author entitles it to careful attention. The conditions requisite to secure primary union are considered to be (1) fair health, especially the absence of any systemic infection of dyscrasy; (2) the removal from the wound of foreign bodies, among which are included blood and serum; (3) the effusion of a moderate amount of coagulable lymph, and (4) no unnecessary violence to the parts in operating. Attention is called to the division of the history of wound treatment into two periods, (*a*) the earlier, in which they were left open to unite by granulation, and (*b*) the latter, when union by adhesion was sought for, beginning in the latter part of the eighteenth century, and to the fact that in the latter period little confidence was felt by many surgeons in obtaining primary adhesion, because of the great frequency of failure. To secure this result the utmost care and attention to details is required of the operator, the lack of which was the most frequent cause of failure. This was seen to a marked extent in military practice, where leasurly care was impossible. It was also observed that anæsthetics had a considerable unfavorable influence, in explanation of which the writer records the observation that, under anæsthesia "the muscles do not quiver and retract under the knife, that they stand apparently lifeless from the wound, as in the cadaver, and that they do not resume their normal contractility until some hours after the operation was completed, the arterial blood is imperfectly oxidized, and the surface of the wound has a dark grumous look, wholly unlike the appearance presented under other circumstances: the effusion of lymph, producing the glazed appearance essential to primary union, may then be reasonably expected to be delayed even beyond the period of possible primary union." He discusses the claims of Lister, to a considerable extent, and attributes his success to careful methods and procedures, rather than to antiseptic precautions, but acknowledges our indebtedness to him for having restored confidence in union by adhesion, and refers to Tait's results in the belief that they ought "to dispose forever of the much discussed question of Listerism in abdominal surgery." He represses his skepticism as to the *role* played by germs in preventing the healing of wounds, referring in sarcastic vein to the criticisms of antiseptics upon the treatment of the case of President Garfield, in which he was one of the consulting surgeons. He disapproves of the substitution of bone for rubber drainage tubes because of their shortness and inflexibility, and seems to prefer silk sutures to those of metal, horse hair or catgut, considering the only advantage of the latter to be in its absorbability, while, on the contrary, it is neither as flexible nor as fine as the finest silk, and, according to his observation, has as great a tendency to form small abscesses. After a tribute to the



value of hot water as a means of imparting a healthy stimulus to paralyzed tissues, of arresting capillary hemorrhage, of removing the blood from the surface of the wound, exposing the ends of the vessels to the ligature, and of coagulating the albumin, while, unlike carbolic acid, corrosive sublimate and the like, it is absolutely innocuous, he closes by expressing his belief that the tide of professional opinion is setting strongly toward a rejection of Lister.—*F. H. Hamilton, M.D., in New York Med. Rec.*

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### THE PROPHYLAXIS OF ASTHMA.\*

Many years ago, when Trousseau was urging the value of belladonna in the treatment of spasmodic asthma, I began its use in certain cases where the disease affected children. Occasionally I got good results—occasionally failure. Subsequently, when the bromides were brought prominently forward as anti-spasmodics and, combined with belladonna, were so much used in the management of whooping-cough, I began, as some one had suggested, the administration of the bromide of potash and atropia as a prophylactic in asthma. The results have been so satisfactory that I wish to ask attention to the treatment.

What I am about to say applies exclusively to children, for, as seen in adults, asthma has usually existed so long that it has wrought changes in the pulmonary apparatus quite beyond the control of the remedies under consideration; and, even in children, the full good of the drugs is only obtained when these are given with the utmost regularity during long periods of time, and in doses sufficient to produce their distinctive physiological effects. Under these conditions, conjoined to certain hygienic measures which I will mention further on, I am persuaded I have prevented asthma from fixing itself on many subjects who otherwise would have become permanent sufferers from the dismal affection.

Perhaps, by describing the management of a case, I shall be able to put what I wish to communicate in the fewest words:

One night in July, 1865, I saw a well developed girl, 6 years old, in a sharp asthmatic seizure, which was soon relieved by a few doses of tincture of lobelia. I found that for two years before she had been subject to such attacks whenever she caught cold, and that the paroxysms had gradually grown more frequent, less and less "cold" being required to excite them. She was usually much worsted by a seizure, two or three days elapsing before she felt fully well again.

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\*The notes of which this paper is an abstract were made in the main while the writer occupied the chair of the Theory and Practice of Medicine in the University of Louisville.

At my next visit I directed ten grains of bromide potash to be given in a glass of seltzer water every morning on rising and at bed-time. To the latter dose was added the  $\frac{1}{10} \frac{25}{100}$  of a grain of sulphate of atropia. The mother was instructed as to the pathogenic effects of the medicines. Two days after it was found necessary to increase the bromide by 5 grains at a dose, which soon produced anæsthesia of the fauces, when the quantity was reduced to 12 grains, an amount which was not exceeded. Dryness of the throat and slight dilatation of the pupils followed after four days' use of the atropia. This medication was continued steadily for three months. Throughout the greater part of this time, the patient had iron and strychnia after food. She was required to live in the open air and take a cold sponge-bath daily. She was provided with a cough mixture containing a considerable quantity of opium, and her mother directed to use it on the appearance of the first symptoms of a cold. She had in the period named but two attacks of asthma, both slight. In the ninety days preceding the treatment, she had five attacks. The treatment was now suspended for a fortnight, when the weather growing cold — this was in November — it was resumed and continued for the succeeding four months. In that time she caught several slight colds, but had no asthma until in March, when, after a wetting in a sleet, she had a mild seizure that yielded to 5 grains of Dover's powder. This was her last attack. For the next four months the medicines were given fifteen days in each month, and then omitted until the following December, when they were given uninterruptedly for sixty days. Ten months having passed without a seizure, notwithstanding the patient had suffered several sharp catarrhal attacks in the time, further treatment was deemed unnecessary. It is proper to add the patient made no change of house, and had practically the same surroundings during the entire time. She remains free from asthma to this day.

Since this case I have treated by the same method eight other cases of asthma in persons aged respectively three, 10 years; two, 11; one, 12; one, 13, and one 14 years old. All recovered but two, and in neither of these was the treatment fairly carried out by the parents. None were dismissed under fifteen months, while two were under treatment for two years.

In five of the nine cases, the disease was hereditary, Eight of the nine were unmistakably neurotic. Perhaps this fact may serve as an explanation of the success of the treatment.—*David W. Vandell, M. D., in Amer. Practitioner.*

## RECTOCELE—VAGINITIS.

In concluding a clinical lecture as reported in the *College and Clinical Record* for March Dr. Parvin presents the following on the above subjects:

This patient is forty years of age, and for the last two years has suffered with a leucorrhœal discharge due to inflammation of the vagina. This has produced vulval erythema, and great itching and burning. The bowels are costive, and there is rectocele. Those of you near can see very plainly the rectocele and the erythematous inflammation. I want to direct your attention to the perfect character of the perinæum, and yet in spite of this we have a rectocele. The importance of the perinæum as a support for intra-pelvic organs has been strongly maintained; less in very recent years, thanks to the teaching of Emmet, than a decade ago. If there be long-continued vulval pruritus, whether from erythema or other causes, it is not unusual to find the inner surfaces of the labia majora greatly changed in character; they become thickened, rough, and have a light ash color, or that of old parchment. Intense itching torments the poor patient so that she is compelled to scratch the parts, and this repeated so often, probably causes the changed character of the internal labial surface. You will meet with the described condition in fleshy women after the menopause.

In the patient before us the inflammation of the vulva is caused by the vaginal discharge, and hence we must cure the latter in order to get rid of the former. By the way, as illustrating the fact previously stated as to the acidity of the vaginal secretion, I will place a piece of blue litmus paper in this discharge, and you see how instantly and completely it is reddened.

Let us, in the treatment of vaginitis, first use simple measures: I will order injections of warm borax water, to be repeated three, four, or five times a day. This will prove very soothing also to the external inflammation. If this is not sufficient, I shall order suppositories containing the following—

R.	Iodoformi,	5 grains.	
	Ex. belladonnæ,		
	Morphiæ sulph.,	aa.	$\frac{1}{2}$ grains.
	Butyro-cocain.,		q.s. M.

One of these is to be introduced into the vagina every night.

If this does not cure the vaginitis, the vagina will be penciled with a solution of nitrate of silver. In doing this a Sims' speculum, with an "elevator" to lift up the anterior walls of the vagina, should be used. Then the mucous membrane should be thoroughly painted with a solution of 5 to 10 grains of nitrate of silver to the ounce. For the external inflammation, we might



employ a weak solution of corrosive sublimate ( $\frac{1}{4000}$ ), carbolic acid, hydrocyanic acid, or chloral in solution. As a rule, ointments are not used to the external genital organs, especially if the inflammation has extended to the sebaceous follicles. Ointments under such circumstances, even if they contain suitable remedies, will usually be found injurious, while on the other hand the use of an alkaline wash will often accomplish much good, for the alkali dissolves the accumulated sebaceous secretion. A solution of carbolate of zinc, or of subacetate of lead often proves useful in vulval pruritus. Hot water as a local application often proves valuable in a pure pruritus; that is, where there is no inflammation causing the intense itching.

### THE ACTION OF CHLORATE OF POTASH.

J. von Mering, of Strassburg, has written up an exhaustive study of the physiological, toxic and therapeutic action of chlorate of potash. He finds that the larger amount of the salt passes through the kidneys unchanged, but that a portion is reduced in the blood. The exhibition of the salt is accompanied by increased excretion of water and increased albuminous waste. The degree of the blood alterations was found to be in a direct relation to the degree of fever and to the amounts of salt given. The other chlorates, those of sodium, baryum, calcium and ammonium, have a similar effect upon the blood. This change consists in a reduction of the  $KClO_3$  by the oxyhemoglobine to  $KCl$ ; methemoglobine results.

Two forms of intoxication are to be distinguished, the one acute, the other subacute. The symptoms of acute poisoning are dyspnoea, cyanosis, vomiting, profuse diarrhoea and heart failure. *Post-mortem* examination shows the blood of a chocolate color. No other lesions are usually found with the exception of insignificant alterations in the kidneys.

The symptoms in the subacute poisoning are jaundice, livid discoloration of the skin, vomiting of biliary matter and epigastric tenderness, diarrhoea, swelling of liver and spleen, albuminuria, oliguria, anuria, etc. Uremia is the cause of death. The autopsy shows the peculiar blood changes referred to. The tumefied spleen and liver are filled with broken down red corpuscles; pronounced renal lesion and discoloration of the medulla of the bones are also found.

According to von Mering the following considerations should guide us in the administration of the remedy: First, the salt should be given after meals; second, quite an interval should occur between the several doses; third, the salt should not be given



in high fevers on account of the diminished alkalinity of the blood; nor in respiratory trouble such as emphysema, pneumonia and the dyspnea attendant upon obstruction of the larynx by croup and diphtheria and the cynosis of valvular disease of the heart—a contra-indication exists also in renal mischief attended by diminished excretion.

In cases of poisoning by chlorate of potash an emetic may be given or the stomach emptied by the syphon-tube. Next in order large doses of bicarbonate of soda should be given, with a view to establishing an increased alkalinity of the blood. The toxic effect upon the red blood corpuscles is most deleterious and marked in a neutral or weak alkaline fluid. For the stimulation of the kidneys large amounts of milk and water may be given. No drink containing carbonic acid, such as champaign, and no mineral acids are permitted, on account of their effect in reducing the alkalinity of the blood.

The author recommends the use of chlorate of potash in stomatitis, mercurial and ulcerative, in ozena, caries and ulcerations. He pronounces against its use in diphtheria, excepting as a gargle. The maximum dose for an adult is, according to von Mering's study, two grams ( $\frac{1}{2}$  drachm) pro doci, 8 grams pro die. Children from 10 to 14 years of age should get a diurnal dose of not more than 4 grams (1 drachm); smaller children, from 2 to 10 years old, should have administered not more than two to 3 grams pro die; infants only 1 gram at most.—*Medical Review*.

## OFFENSIVE URINE.

An English physician says he has met with no case of offensive urine (intestinal-vesical fistula excepted) that ten or twenty grains of boracic acid given every three hours would not cure.—*Canadian Practitioner*.

## PELVIC NEURALGIA.

In congestions or plethora of the pelvic organs, with accompanying neuralgia, in women, the following formula frequently gives decided relief:

R.	Pot. bromid,		
	Ammo. bromid,,	aa	1½ drachms.
	Tinct. guaiac.,		
	Tinct. colchici., rad.,	aa	fi ½ ounce.
	Syr. simp.,		3 ounces.

M. SIG.—Teaspoonful three times a day.

## NERVOUS ASTHEMA.

At Prof. Da Costa's clinic, recently, there was a boy, aged four years, who had had *nervous asthma*, since he was one year old. He was given

R. Sodii bromidi,	3 grains.
Tinct. belladonnæ,	1 drop.
Syrup tolutan.,	
Aquæ, of each	fl ½ drachm.
M. SIG.—Ter die, well diluted.	

## RENAL INADEQUACY.

For a case of *renal inadequacy* and *gastric catarrh*, the same authority ordered a strict diet, argent. oxid.,  $\frac{1}{10}$  grain *ter die*, a saline for the bowels and for the kidneys:

R. Potass. acet.,	20 grains.
Tinct. zingib.,	20 drops.
Elixir, simp.,	
Aquæ, of each q. s.	ad 2 diachms.
M. SIG.—Every third hour, well diluted.	

## SCABES.

The following is Hebra's modification of Wilkinson's ointment:

R. Flor. sulphur,		
Ol. fagi.,	of each	1½ ounces.
Creta alb.,		1 ounce.
Saponis viride,		
Ungt. simpl.,	of each	3 ounces.
M. Rub thoroughly into the skin after a hot bath.		

## ANOTHER USE FOR COFFEE.

Chewing coffee is said to effectually remove the disagreeable taste following galvanism to the head and neck.

## OUT OF PLACE.

The *Cincinnati Medical News* affirms that: "A physician who does not pay for his journal is not fit to practice medicine. He had better be engaged in driving mules to the market and let his M. D. stand for mule driver." It looks as if some of the *News* subscribers were dilatory in paying their bills.—*Lancet*.

# THE PEORIA MEDICAL MONTHLY.

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## EDITORIAL.

### THE REGISTRY LAW.

Dr. Rauch, Secretary of the State Board of Health, has, through the aid of the clerks of the various counties in the State, secured the names as nearly as possible\*of all those physicians who have during the past year failed to comply with the requirements of the law in relation to the reporting of births and deaths. To these he has sent notices of their delinquency, together with an expression of regret at the necessity for so doing.

Now, whilst this action on the part of the State Board is eminently in keeping with its official duty, as we understand it, the necessity for it is highly suggestive of a state of affairs deserving of consideration. That physicians generally, even a large proportion of them, do not comply with the requirements of the law, argues two points: First, that they do not have much, if any, faith in the power of the Board to enforce the demands of the law; and second, that in the present status of affairs, at least, little if any scientific or practical value can be attached to such returns.

As to the first point, we have heard it said by physicians

again and again, backed by the opinion of able lawyers, that the State cannot compel them to give the time and labor necessary to its demands in this regard without at least a nominal pecuniary compensation; that the time and labor involved, as well as the unpleasant feelings engendered on the part of many in being compelled to spread before the public gaze matters which they think are of only family concern, render the demand an unprofitable and disagreeable one, to which the physician is justified in giving little heed.

As to the second point, there is an equally widespread feeling that the inaccuracies of incompetents, coupled with the numerous omissions of those freed from duty through the ten-year exemption clause of the Medical Practice Act, are sufficient to almost completely vitiate the value of the returns for the purposes of either the scientist or statesman, and therefore entail upon the otherwise willing members of the profession a needless, or rather a useless, expenditure of time and labor.

What will be the final outcome of the present attempt to excite obedience to the requirements of the law in this matter we know not, but certain it is that many practitioners are delinquent in this regard for the above mentioned reasons as well as for others perhaps of which we know not but hope to hear through the pages of *THE MONTHLY*.

Apropos of the farcical light in which the registration law in its present workings is viewed by the public, we append the following extract from a daily paper of this city:

"The inadequacy of the present system of death returns is shown by the last report of the County Clerk to the State Board of Health. According to that report there were but 127 deaths in Peoria County during 1885. Now the City Health Officer's list shows that there were over 600 deaths in this township alone in the same space of time, to say nothing of fatalities in the seventeen country townships. The system is simply a farce. It accounts for but three accidental deaths and one suicide last year, probably a tenth of the whole truth."

O. B. W.

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### ULTRA SCIENTIFIC MEDICINE.

While we would not decry the labors of men of honesty and merit in the domain of scientific research, we would still beg



their followers to allow a little praise to the host of honest practitioners who are forced by circumstances to plod along in what is sometimes sneeringly termed "the same old rut." A very large majority of physicians in this country have not had the advantages of extended laboratory investigation or of years of study in foreign universities and clinics: many of them have not had the advantages of a thorough preliminary education; a host of them have received their medical training under adverse circumstances, having attended lectures long before the cry of a "higher medical education" was heeded by the colleges, and yet these men form the bulwarks of medicine in this country, and in their various spheres accomplish as much good for suffering humanity as do those who decry their modest pretensions.

*We have heard* of a noted professor who, having studied out a scientific treatment for diphtheria, carried it out in his practice, and lost nearly 50 per cent. of his cases, while an *old fogey*, as he would be called, struggled along through the same epidemic with his old and tried remedies and lost but about 15 per cent. His prescriptions would have been laughed at by his famous rival; they would have been called incompatible, unscientific, but his patients got well, and after all that is what we are working to do.

Let research continue, let those who can, strive to wrest from nature her secrets of aid and cure, but do not let us permit the *dillitanti*, ultra scientists in medicine, to decry everything that has not come through them, without a protest.

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#### DR. AUSTIN FLINT.

The sudden death of Dr. Flint from cerebral apoplexy, March 13, removes another of the great men in American medicine. Dr. Flint was born in 1812, and his father, grandfather and great-grandfather were all physicians. He graduated at Harvard in 1833, and began to teach at Buffalo in 1844. During his long career he lectured in Buffalo, Rush College Chicago, Louisville, New Orleans, and finally Bellevue Hospital Medical College and the Long Island College Hospital. He had received all the honors, both at home and abroad, that medical societies have to bestow, and his works have had immense sale.

## NOTES AND COMMENTS.

The conclusion of Dr. Hubbard's comments on "Sex Production" will appear in our next issue.

We hope our readers will enjoy the clinical lectures by various Philadelphia professors, which are especially reported for this journal.

The members of the State Board of Health of Pennsylvania are making preparations for holding a national sanitary convention at Philadelphia in May.

Probst says: "By means of the paths of nervous communication between the brain and body, the mind may be said to be universally present in the body."

Parke Davis & Co. have issued a handsome volume on coca and its various preparations. It is a complete manual of this drug, and is a valuable contribution to its literature.

Dr. N. S. Davis of Chicago had a slight apoplectic attack some time ago, but we are happy to state he has entirely recovered. We hope his useful life will long be spared for his work.

A full index for Vol. VI will appear in our next issue. With the May number begins the seventh volume of what many Illinois doctors predicted would not live six months. Thanks.

Says a newspaper exchange: "The labor troubles have not extended to Spain, but are expected in about a month. The question in the royal palace whether there is to be a boycott or not."

A wise St. Louis physician cured a case of alcoholism by prescribing opium. He then cured the opium habit by giving cocaine. Now he is searching for a cure for the cocaine habit. — *Puck*.

The following treatment of freckles is recommended in the *British Medical Journal*, Aug., 1885: "Dissolve 12 grains of mercury in 2 ounces of rectified spirit and 6 ounces of distilled water. Apply daily after washing, and at night."

Of the 672 Yale graduates who died in the ten years between 1876 and 1885, there were 271 who were past 70 years

of age. And these men received their education when candle-lights were used at morning prayers.—*Yale Courant*.

A writer in the *British Medical Journal* advises people to be careful not to slice up a pineapple with the same knife they use in peeling it, as the rind contains an acid organic substance which is likely to cause a swollen mouth and sore lips. In Cuba salt is used as an antidote for poison of pineapple peel.

In the old days it was the duty of English coroners to hold inquests not only on deaths, but on fires, burglaries and robberies. Inquests on fires are still held in Northumberland, and it is now promised to reintroduce into London the ancient "crownor's quest law" in the matter of fires.—*New Orleans Times-Democrat*.

Says the *American Lancet*: "Dr. Purdy of New York has been fined \$500 for reporting to the Board of Health a case of small-pox, while Dr. G. P. Dennler of Long Island City has been indicted for not reporting to the Board of Health a case of small-pox. Punished for reporting and punished for not reporting, choose between them ye doctors."

It is related of a Detroit doctor, that he was called to see a lady who supposed she was pregnant. He entered the house and took in the surroundings, a poodle dog here, several birds there, a cat yonder, and other things to match. He at once turned on his heel with the exclamation: "Hell! There is no baby here." Later developments proved his diagnosis correct.—*Lancet*.

A St. Paul dispatch of March 2d contains the following: "Dr. Gale, who figured prominently in the double tragedy at the Astoria Hotel Saturday, whice resulted in the death of Rich and his wife, this morning received a letter signed "By order of a Committee of Ten," stating that he must the city immediately or he would be "introduced to a lamp-post and presented with six feet of hemp." The police have the letter and are on the watch."

A writer in the *Journal of Mental Science* gives the results of a series of experiments to determine the comparative action of coffee and alcohol, He finds that while alcohol increases the

production of heat, it really lowers the bodily temperature by virtue of exaggerated radiation. The caffeine in coffee, however, preserves the heat, and thus, if given in conjunction with alcohol, restrains the tendency of the latter to lower the temperature.—*Exchange*.

Jerome B. Chaffee, who has just died, had a profound disbelief in doctors. This peculiarity of his led to innumerable over the death-bed of Grant. The Senator insisted that the General's case should be entrusted to the care of specialists. In this he was sustained by Stephen B. Elkins. The family would not listen to it and Chaffee used to go out at midnight for a walk and fill the reporters' heads full of growls about the way the physicians were managing the case. Curiously enough Chaffee's own death is said to be due to his refusal to follow the instructions and advise of his doctors.

We are assured by science that there are many chronic maladies that tobacco aggravates and hastens. I remember an instance that is historical. An aged and illustrious Chief Justice of the United States Supreme Court lay dying in the city of Baltimore. "Doctor," said he to his medical attendant, one of the most famous members of the faculty in America, "what do you think of the prospect?" "My dear Judge," the doctor replied, "we think the time has come for you to know that we can do little or nothing for you. Tobacco must have aggravated your disease." "Yes, doctor," assented the dying jurist in a voice that was barely audible, "I have thought so myself for the last sixty-five years."—*Cor. Detroit Free Press*.

In my opinion the practice of medicine will be revolutionized within the next few years. We will live to see the student and successful practitioner of to-day retire altogether from the actual practice of medicine, and establish himself as a consulting physician only. The learned surgeon or physician of the future will devote more time and attention to the prevention than to the cure of disease. It is no great trick to learn to set a fractured bone or prescribe a dose of salts. Such things will be relegated to a class of practitioners about on a par with what are now called nurses. Hygiene and sanitation will be the study of the physician of the future. Of course he must have a knowledge



of drugs, anatomy, physiology and such matters, but his office will be that of a consultant. The bone-setters and drug-prescribers will lay their cases before him, and he will advise them pretty much as the advice of an old established counselor at law is sought by an attorney. The great question of the future will not be so much the cure as the prevention of disease.—*Dr. Montrose A. Pallen.*

When Prof. Frank Billings sailed for France with the children from this city who were treated by M. Pasteur, he exhibited a lamentable ignorance of the French language to the passengers and officers of the steamship Canada. In Paris he was likewise ignorant, and Pasteur was somewhat surprised that a scientist should have been chosen to accompany the expedition who could not converse with him without an interpreter. He would have been more surprised had he followed Dr. Billings home and heard him converse in elegant and masterly French with Mrs. Billings, who is a native-born French woman. In fact, the Professor kept it mighty quiet in Paris that he was a finished French scholar. He had a laudable object in view in assuming ignorance. He went to Paris to learn something, and knowing that the Frenchmen are jealous of their secrets he wisely concluded that he could learn more by listening than by asking questions. The ruse was successful, and he came back the possessor of a great deal more information about viruses than M. Pasteur is aware of. In fact, he discovered some facts not yet known to the scientific world.—*Newark (N. J.) News.*

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### BOOK NOTICES.

THE DIAGNOSIS AND TREATMENT OF DISEASES OF THE EAR.  
BY OREN D. POMEROY, M.D., Surgeon to the Manhattan Eye and Ear Hospital, etc., etc. With 100 illustrations. Second Edition. Revised with additions. 8vo., cloth; pp. 413. D. Appleton & Company, New York. 1886.

The appearance of a second edition of a work on a special branch, within three years, speaks highly of the reception given it by the profession. This work of Dr. Pomeroy was written especially for the general practitioner who is compelled to give some attention to diseases of the ear, and it seems well adapted to the needs of this large class of physicians. It is plain and

practical in every way, and will long be one of the standard works on this subject.

**THE METHODS OF BACTERIOLOGICAL INVESTIGATION.** BY DR. HUEPPE, Docent in Hygiene and Bacteriology in the Chemical Laboratory of R. Fresenius at Wiesbaden. Translated by Hermann M. Biggs, M.D., Instructor in the Carnegie Laboratory, etc. Illustrated by 31 wood-cuts. 8vo., cloth: pp. 218. D. Appleton & Co., New York. 1886.

This work was written at the suggestion of Dr. Robert Koch and is intended as a trustworthy hand-book for the beginner in the field of bacteria investigation. It will probably be widely used as a text-book in laboratories where this important subject is made a part of the course of study.

**LECTURES ON SYPHILIS.** Delivered at the Chicago College of Physicians and Surgeons. BY G. FRANK LYDSTON, M.D., late Resident Surgeon Charity Hospital, New York, Lecturer on the Surgical Diseases of the Genito-Urinary Organs and on Venereal Diseases in the College of Physicians and Surgeons Chicago, etc., etc., etc. Reported by W. A. Walker, M.D. 16mo., cloth; pp. 184. A. M. Wood & Co., Chicago, Ill. \$1.25.

This work contains nine lectures on syphilis reprinted from the *Western Medical Reporter*. They are printed, we presume, as originally delivered, as the style is easy and rather colloquial. The author's views are sound and his work can be recommended to students, although practitioners will be able to enjoy it and profit from its perusal.

**LOCAL ANÆSTHESIA IN GENERAL MEDICINE AND SURGERY.** Being the Practical Application of the Author's Recent Discoveries. BY J. LEONARD CORNING, M.D., etc., etc. 8vo., cloth; pp. 103. D. Appleton & Co., New York. 1886.

This is a valuable little work on cocaine, giving the author's method of increasing and prolonging the cocaine anæsthesia by incarcerating the anæsthesia in the field of operation by means of compression of the blood vessels, after the injection has been made. Some very formidable operations, even amputations of the thigh, have been performed by this method and with but very little pain. It is a valuable contribution to surgical practice.

## RECEIPTS.

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## CLINICAL LECTURE.

### INCIPIENT LOCOMOTOR ATAXIA.

BY PROFESSOR ROBERTS BARTHOLOW, M. D., PHILADELPHIA, PA.

[Delivered in the Hospital of the Jefferson Medical College March 1.]

The first case which I bring before you to-day, gentlemen, possesses very great interest from a diagnostic standpoint. You will not infrequently be confronted with such cases, and it is of the utmost importance that you should be able to recognize them, for your only hope of relieving the patient will rest upon a correct appreciation of the condition. There are some very fine points involved in the diagnosis and we will consider them together. We have presented to us a man apparently robust and vigorous, who is in the prime of life, and who comes to us to be relieved of a derangement of his sexual organs. At first, he tells us that he was troubled by an unnatural excitability of these organs, he had a great and unusual desire for sexual intercourse, and his organs and power seemed to be in good condition, save only for his hyper-excitability. This condition was followed by a decline in this passion, when he found himself unable to have an erection, he was troubled by nocturnal emissions and there was a growing inability to satisfy the demands that existed. On the least exertion, he would have a discharge of semen. Such is the complexus of symptoms which he offers to our observation, and I need not tell you that such a condition has caused him much anxiety, for there are few things that will so worry a man as have anything wrong with his sexual apparatus. A man in



his condition suffers morally in his character, for he soon acquires the reputation of possessing inordinate sexual desire and if he gratifies it he is apt to secure a somewhat bad moral character. When a man of good physique, and apparently robust, exhibits an excessive sexual desire, his neighbors are very apt to calumniate his moral character, which is an additional reason why you should be on the alert to detect the true nature of the trouble. Well now, when a man, in vigorous health, to all appearances, comes to you complaining that he has been troubled by hyper-excitability, followed by a decline in power of the sexual organs, what would you most naturally expect to be the matter with him? Well, if you were to consider the condition of the sexual organs as they present themselves to you, without looking any further, you would be apt to say the man was suffering from spermatorrhœa. But it will not do to thus make a snap diagnosis, for, since such a condition may be due to other and much more serious causes, you should look further and see whether they are not due to some disorder of the nervous system. Well, what disease of the nervous system might give rise to such phenomena? We are all familiar with the fact that this abnormal condition belongs to the early history of locomotor ataxia, the very first indication of which may be, in some cases, this increased excitability of the nervous system. Well now, have we, in this case, any other symptoms of that peculiar malady? One of the very early symptoms, as you know, is a loss of the patella-tendon-reflex; so I at once proceed to look into the condition of the knee-jerk in this case, and I find that when I make a very strong stroke I elicit a very feeble response; it is very feeble and only produced when the leg is held in one particular position. Therefore, I say, that while the knee-jerk is not entirely absent, yet it is disappearing. Well, having elicited this important sign, we ask are there any further evidences of locomotor ataxia?

We now inquire more critically into his history and we find that, although he is a vigorous man, in his prime, about forty years of age, he has some trouble with his eyes; he has amblyopia and he has been compelled to wear glasses that ought ordinarily only to be used by a much older man. In this fact we see also a symptom that is peculiar to the early stage of locomotor ataxia; he has also probably at times had double vision. This

condition of the eyes I would impress upon you as of great importance, for you will be very apt to erroneously attribute it to the unusual decay of age, and thus overlook its importance as a diagnostic sign that will enable you to recognize this terrible disease in its incipency, when you can hope to do some good for your patient. Of course, taken by itself, it amounts to nothing, but when the power of vision is affected in connection with this disorder of the sexual system and there is diminution or loss of the knee-jerk, then it is a very pregnant symptom, and one that may serve equally to aid you in arriving at a conclusion in what would be otherwise a very obscure case. It is just such a case as this one that will tax you greatly when you get out into practice.

It seems comparatively simple, when you hear me unfold the case before you, but when you are compelled to rely on yourself solely, when you have no one to consult, and when, under such circumstances, a man comes to you offering only a few obscure symptoms, each one of which might belong to any one of several diseases, you will find yourself non-plussed unless you remember these little points, and unless you cultivate the habit of considering the complexus of symptoms, the relative importance of each as associated with the others, as well as the significance of each individual symptom.

Now, also one of the earliest symptoms of locomotor ataxia and one that very frequently is erroneously viewed, thus leading to a misconception of the trouble which afflicts the patient, is the occurrence of muscular pains, lightning-like in character. They occur in the initial stage, as I have said, are shooting and are usually noted in the extremities. There is frequently associated with this pain a sense of constriction in the part, a binding feeling, like pressure, and it is very usual for this condition to be mistaken for rheumatism. It might last for years and the patient telling you that he was rheumatic, and you accepting his say so without further investigation, might suppose the pain to be due to rheumatism or neuritis, when in reality it was really due to a commencing locomotor ataxia. We make inquiry about this symptom in this case and find that it is wanting. The man says that he occasionally has some pain in his back and some uneasiness about his limbs, but no marked shooting pains.

The absence of this sign tends to negative the idea of locomotor ataxia, but it is not proof positive that the disease does not exist, while it is most usually present, yet it is not always so. As the the disease progresses we will have anæsthesia of the sole of the foot and disorder of muscular motion, but these characteristic symptoms have not yet become manifest in this case. It is still in the first stage, and the history which the man gives us as well as the signs which we are able to elicit correspond very clearly with the history of the early stage of locomotor ataxia in every particular save that of the absence of muscular pain, which I must admit is a strongly negative sign. In the course of some months, it may be a year or two, according to the rapidity with which the disease progresses, we will have the knee-jerk completely abolished, we will most likely have the muscular pain and the other characteristic symptoms. Well, now then we have to do with a case in its incipency, when the symptoms referable to the sexual system are marked, later these symptoms will be wanting.

Having a case thus early in the disease, what can we do for it? I would call this a favorable case for treatment, the man is in good condition, the morbid process has but just commenced, and altogether I would feel that we had good reason to hope that we may be able to cure or at least to check the progress of the disease. It is of the utmost importance that these patients should rigidly and persistently carry out our instructions for a long time; it will be idle to attempt to relieve such a case by spasmodic or intermittant medication, the effort must be earnest and prolonged or it will be useless. This fact should be earnestly impressed upon the patient, for, as a rule, when prolonged treatment is necessary in any case, it becomes irksome and the patient rebels against it and will not persevere, save in very exceptional instances. However, if you explain the necessity of perseverance, if you tell the patient that you can do him no good unless he strictly follows your directions, then you have placed the responsibility of failure where it rightly belongs and your conscience will be clear. Premising then, that persistent treatment alone can be expected to do any good, we ask what drugs are calculated to be beneficial in such cases: what group of drugs are indicated in the initial stage of locomotor ataxia? What are known

as the metallic tonics, so to speak, are the drugs that we will derive the most from.

Prominently among this class I would place nitrate of silver, which, when persistently used is eminently calculated to cure or, as I have said, at least to control the progress of the disease. So I would also mention chloride of gold and sodium, which I would think at least as efficacious as nitrate of silver, if not more so. Now, a very important question in the therapeutics of the disease arises. You are probably aware that syphilis is a very common cause of locomotor ataxia, indeed some authorities go so far as to say that the disease is always caused by syphilis. This question has been much debated and it would seem, as some suppose, that while the disease is not directly caused by syphilis, yet it is, so to speak, evolved from it, if you catch my meaning. That is to say that while locomotor ataxia is not a symptom of active, acute syphilis, yet the specific affection may cause such changes in the nervous system as to favor the development of the disease, so that while the disease, to repeat, may not be the direct result of, it is yet induced or favored by syphilis, which must be recognized as a potent factor in very many cases of the disease. Therefore we must, of course, perceive that this question will have an important bearing on our therapeutics. If we know that there be a specific taint, and especially if the disease be of recent date, it is obvious that we would resort to iodide of potassium. In this case we can get no direct history of syphilis that would cause us to assign to it a causative influence, but I would say, in general terms, that when you suspect the existence of a specific influence, it would be good therapeutics to use the iodide of potassium. In this case, as we have no reason to suspect syphilis, I will order the nitrate of silver in pill form. You know that this drug has the property of accumulating in the system when used for a long time and producing very unpleasant results thereby, among which I might prominently mention the characteristic discoloration of the skin, yet that it may do good, it must be used for a long time, hence I will give you some directions by the observance of which its use may be long continued, without any deleterious effects. The patient should take it continuously for six weeks and then suspend its use, being then thoroughly purged and other measures resorted to in order



that the accumulated drug may be removed from his body by means of the excretory organs. After an interval of two weeks he should recommence the drug, continue it again for six weeks, suspend it, eliminate it as before and so on. By thus cautiously handling the drug its use may be persisted in for so long even as two years, but do not forget that all this caution is imperatively needed. Have we then anything else that will do good? Yes. The electric brush has been highly lauded by some authorities and I am quite well satisfied that its use will be frequently productive of very good results. The electric brush means the application of faradism to the whole surface of the body; the patient may stand with his feet on a metal plate and the poles be applied to every portion of the surface of the body from the top of his head to the soles of his feet; it must be thus thoroughly applied or it will do no good. Some authorities claim that they have succeeded in arresting the disease in very many cases by the use of the electric brush alone, without any other remedies. Whether this is really true or not I am not prepared to positively state, though a comparatively small amount of positive evidence in this, as in any other direction, will outweigh a much greater amount of negative evidence, and I am quite sure that its effects are sufficiently good to warrant us in giving it a very thorough trial in every case that we have to treat.

Electricity is a remarkable remedy in all disordered conditions of the nervous system, and it is a remedy the great importance of which I fear has not hitherto been properly appreciated. The field of its applicability is a very vast one, and I am quite sure that in the near future we will see it in much more common use in general practice than it is at present. Now, how shall we use the electricity in this case? It is a very common mistake that is made by the general practitioner who has not an intimate acquaintance with this valuable therapeutic resource, to use it in too strong quantities and thus, instead of doing good he really injures his patient. I would lay down the rule that it should be used in such quantity only, as will produce a pleasant sensation, an agreeable titillation. The very strong current, as I have said, and I repeat it, because you should remember it, will prove injurious, while if you use the weak current, affecting

only the skin, that is directly acting on only the skin, and not producing pain, but only pleasant feelings, and if you keep this application up you will surely do good. Well now, what else will we do? The electric brush and the nitrate of silver will be our main-stays, with them we will hope to do the most, but we will, of course, have some collateral indications to take into account. Of these I would consider the first and most important to be rest. Some authorities say that the patient should be kept in bed for a month or more at a time. While I say they should have rest, yet I believe in a certain amount of exercise, but we must be very careful that this is not carried to a point of fatigue for then it will prove very injurious. I would say that when we get hold of a case early in its course, we can do a great deal to ameliorate its severity by rest alone. As I said, a few minutes ago, about electricity, so I would say of rest, it is a therapeutic resource of wonderful potency, one that is not properly appreciated by the profession and one that I am quite sure will be more generally resorted to when its importance is rightly appreciated than it is to-day. But we can hope for but little from rest unless we pay attention at the same time to the patient's diet. We would make a great mistake, as you can plainly see, if we were to allow the patient to consume his usual quantity and quality of food, that which he was accustomed to take when leading an active life, and yet, at the same time, keep him on his back in bed; we would soon derange his stomach and his assimilative functions, we would soon overload his system with unnecessary aliment and would thus, evidently, do more harm than good. We well know that if a man leads a sedentary life and does not regulate his diet in accordance therewith, he will suffer in consequence. Nature's law regulating the supply cannot be infringed with impunity. Therefore when we enjoin rest we must caution the man to be very careful not to eat to excess, and indeed the diet must be materially reduced. From each individual case we must draw the indications for the kind of restriction we will impose upon the diet. If the patient suffers from indigestion at all, we must inquire into its nature and expel from the dietary the offending articles. Thus, if he has acid indigestion we must exclude the fats, which, by fermentation generate butyric acid, and

so on for each class of foods we must study the special indications that each case presents.

Thus you see, in conclusion, that it has been from an aggregation of small, and many of them apparently irrelevant symptoms, that we have reached the conclusion that this man is suffering from incipient locomotor ataxia and it is from a combination of apparently small methods, such as diet and exercise and rest, combined with the electricity and silver, that we hope to benefit him.

#### SPASTIC MUSCLES—THE RESULT OF MENINGITIS.

Look at the peculiar shape of this woman's hands. See how deformed they are, and let me tell you that this is a case that is well calculated to deceive you at first glance. Can any gentleman make the diagnosis? You say "Rheumatoid Arthritis," and you say "Arthritis Deformans." Well, now, it is an arthritis deformans, in one sense of the word, because there is marked deformity, apparently, of the joints, but it is not *the* "arthritis deformans," and, as I had supposed, the condition of the hands has deceived you into a false diagnosis. Let us inspect the hands carefully and we see that this deformity is entirely due to muscular contraction, to muscular spasm, and when, by pressure, I forcibly overcome the resistance to these spastic muscles, you see that the hand assumes its normal appearance and there is no true deformity of the joints as we would have in rheumatoid arthritis. There is a spastic condition, a state of over-action of certain groups of muscles. Let us inquire into the history and see whether we can find out the cause of this unusual contraction. We learn that it commenced about two years ago, following an attack of sickness, and that it has persisted ever since. Now I have asked her to speak because I wanted you to notice the peculiar action of the muscles of the face. You could see how those on the right side seemed to over-act, as it were, while those on the left were in a more or less parietic state, thus in consequence the mouth and nose were drawn to the right: sometimes in this same case we have just the reverse and the nose and mouth are drawn to the left. Thus you see there is a want of co-ordination, a want of balance in the action of the muscles, one set over-acting, while the opposing set

are in a state of under-action. We then observe, as I say, a spastic condition of the muscles, let us see what has caused it.

The attack of sickness which she tells us was the forerunner of her present trouble, commenced with a pain in her big toe, which, I assume was, of course, the outward manifestation of some central trouble; she had also at the same time much headache and some dizziness. After she had had this pain in her toe for some time, she was alone one day in her room, when she tried to walk across the room to her bed, and in doing so fell to the floor unconscious. She was then sick for three weeks, during much of which time she had more or less stupor and delirium. This much we learn from her, but we cannot get a very clear history of the attack, owing to the ignorance of herself and her attendants, but we learn enough to satisfy us that her sickness was characterized by delirium and stupor and nervous symptoms. Well now, what disease would we have the most right to assume that she had? I would say meningitis and most likely cerebro-spinal meningitis. This disease leaves many sequellæ, many after-claps, and I would assume that the spastic condition of these muscles was one of them. It will sometimes leave its mark on the special senses and sometimes on the extremities, in the shape of various forms of paralysis. What lesion, following meningitis, let us ask, would give us this state of the muscles? The joints, as I have told you, are not changed, and when I oppose the force of these contracted muscles, I can put the hands into their normal condition. Well, I would say that coarse lesions of certain kinds and in certain positions could give us these conditions. They could be caused by exudations making pressure on motor nerves and so, if slight, stimulating them to excessive action, and if more severe, producing a more or less paretic condition.

Well, if we can so explain the occurrence of these phenomena, as I think we can, the eminently practical question next confronts us, can we relieve this condition, and if so, how? If I am correct in my assumption that there has been an exudation, which has become organized, then, of course, we cannot hope to effect a cure, the most we can do is to ameliorate the awkward and mortifying condition. But as it has been only two years since the commencement of the attack, since the disease is there-



fore comparatively acute, and since we would therefore infer that complete organization of the exudate has not yet occurred, I think that we are justified at least in hoping that we may be able to do some good. Well then, starting out with the idea that we have to deal with an exudation, what remedy would we expect to do the most good? I would reply, iodide of potassium, which is generally accredited as possessing remarkable absorptive powers; hence, on account of its general reputation I would place it in the first rank, though, for myself, I have usually derived the best results from the use of minute doses of corrosive sublimate; say the one-thirtieth of a grain twice daily, continued for weeks or even months. But ought we simply to confine ourselves to the use of this drug? Can we not employ some remedies that are capable of acting directly on the spastic condition of the muscles and overcoming it? Gelsemium is such a drug, and I think that we can do much good if we will give five minims of the fluid extract morning and evening, but I would caution you that if you expect any good results from this drug, its use must be persisted in for a very long time; do not use it spasmodically, conclude that it is doing no good and throw it aside; you cannot hope to accomplish anything by giving a few full doses, it must be taken for a long time. Therefore, in this case I will direct five minims of the fluid extract to be taken twice daily, and in connection with it will order pills containing  $\frac{1}{32}$  grain of corrosive sublimate. Now is there anything else that we can do? Let us see what we have. We have two conditions of the muscles; we have two groups; in one group we find a condition of over-action, they are in a tonic, a spastic state, while those which should ordinarily antagonize this group, while not truly paretic, are yet in a decided state of under-action. By means of electricity we can help to bring about a harmony of action, we can overcome, to a certain extent, the spastic, and we can tone up the paretic muscles. But, how? What kind of electricity must we use? We have rigidity on the one hand and relaxation on the other, not, mark you, really paresis; well, what form of electricity should we use on the over-acting muscles? I say galvanism, the continuous, descending, stable current, passed in the direction of the nerves, this is the form of galvanism that is calculated to quiet the muscles, to contract the spastic condition, while on the other hand

to the under-acting muscles we want to apply the interrupted current, and we will therefore resort to faradism, which will be used sufficiently strong to produce vigorous contractions but not strong enough or long enough to produce fatigue of the muscles. By this combined treatment, of the use of the two forms of electricity, in connection with the use of the bichloride of mercury and fluid extract of gelsemium, we will do more to relieve our patient than we can possibly hope to do in any other way. But we must not promise an absolute cure in view of the probable irremediable nature of the lesion.

## PTOSIS.

Five weeks ago this man had an attack of ptosis. Upon ophthalmoscopic examination, for which we are indebted to Dr. Fox, we find no change in the appearances of the eye-ground, save that the veins are somewhat tortuous. Here you see how the left eyelid droops and is turned somewhat outward; the pupil is dilated, but there are no further cerebral symptoms in the case, nothing referable to the brain as the seat of the lesion. But the symptoms do refer to an important cerebral nerve, to the nerve supplying the eye, because we have not only ptosis, but also an affection of the pupil. He denies a specific history, which might explain the condition by supposing that a gumma was pressing on the nerve. If there were an inter-cranial tumor we would have more characteristic symptoms, while here the symptoms are confined to a narrow space. I have said that he denies syphilis, but when we consider his history, which is that of a soldier for some time and later a pensioner, I am not sure that we can thoroughly accept this denial: we cannot abandon the idea of a gumma, hence massive doses of iodide of potassium would be in order. But suppose they fail to do any good: what then? We must then use remedies that will stimulate the nerve, and physostigma has a remarkable power in this direction. Whatever may be the theory of its action, we know that eserine does contract the pupil. Therefore we would use eserine, if the iodide fails. In connection with this we would make hypodermic injections of strychnia into the temple and use electricity to the eye. But before resorting to these latter remedies we must give iodide of potassium a fair trial, unless we know that it has already been used without effect.

## ORIGINAL COMMUNICATIONS.

RETENTION OF THE SECUNDINES OF ABORTION  
IN THE FIRST FOUR MONTHS OF PREGNANCY.

BY B. F. HERNDON, M. D., WOODBINE, K. Y.

I have been a silent reader of your valuable journal for two years, and seeing nothing from this part of the country, and thinking perhaps a few lines from the "mountains of old Kentucky" might be of interest to some of your many readers, I will report a case that occurred in my practice, although being unaccustomed to writing for medical journals, my report may not be as scientific as it would have been should it have come from the pen of one more versed in the business.

Mrs. F., aged 21 years, the mother of one child, was married when she was 18. Was always healthy during her childhood. Menstruated at 15, afterwards regularly and without pain. Her child, which is two years old, was born at full term. She has never aborted previous. Never had leucorrhœa until being pregnant.

March 18, 1886, 4 o'clock P. M., was called to see patient first time; found her of medium size; pulse, 80. Complaining of weakness, headache and pain in the small of the back and abdomen; no appetite; abdomen not distended; no tympanitic resonance. Sensitive on pressure over the left iliac fossa. On digital examination found external os uteri open sufficiently to admit the passage of one finger. On withdrawing the finger coagula of blood were found on tip. Little sensitiveness of uterus on pressure.

Ordered rest, and one grain powdered opium every three hours. Leaving orders to send for me should any change take place, I told the husband that she was likely to abort. He said, "I reckon not," as he did not think she was pregnant, and that she had been washing the day before, and that he thought "she had only taken cold."

Whether or not he had been doing something he should not have done, and was trying to cover his guilt, or whether he was really ignorant of her condition, am unable to say. Be that as it may, on my next visit, March 19, 8 o'clock, A. M., I was shown a small fœtus that had been passed the night before, nothing else

coming away only a little slime tinged with blood. The patient expressed herself as feeling well only a little weak. Little appetite; pulse, 80; temperature, 100. Discharges much the same as the day before.

Digital examination revealed much the same state as before. During the next day and the day following the patient felt well, under the circumstances. On the night of the 24th, 12 o'clock, was called in haste to see patient; found her weak and anæmic. She went to sleep at dark feeling well and on awaking found herself swimming in blood, and having very severe pains. I ordered cold applications on hypo-gastrium to check hemorrhage, but without success. I then depressed the uterus with left hand, and with the other hand forced an entrance through the cervix and removed the secundines. During this the patient fainted and became still more anæmic. After removing the placenta the hemorrhage ceased as did the pains also.

The contents of the uterus was in a perfect state of decomposition, and very offensive. I ordered moderate doses of brandy with five drops of tinct. ferri. chlo. As vaginal injection I prescribed—

R. Listerine,	3 dr.	
Aquæ,	5 dr.	M.

To be used twice daily.

About one hour after the removing of the placenta, found pulse very weak, 110; temperature, 103.8. On leaving I ordered nurse to notify me immediately in case there be any alarming hemorrhage.

March 25.—Found patient still very weak, but no alarming symptoms. Very slight hemorrhage. I made no digital examination. Abdomen very slightly tympanitic, but no where sensitive. Pulse, 94; temperature, 104.2. Continued same treatment.

Was called at night of same day. Patient extremely weak. Pulse, 102; temperature, 105. Abdomen slightly tender on pressure. Pinched features: complained of some nausea. I suspected an approach of peritonitis. To give her rest, I injected subcutaneously  $\frac{1}{6}$  grain morphia. Patient rested well balance of the night; still feels weak, but improved considerably.



Pulse, 90; temperature, in axilla, 100. Pain in abdomen ceased. Discharges tinged with blood, but no hemorrhage.

General treatment: Good food with the addition of beef wine and iron. The patient improved slowly but steadily under this treatment, and at this writing (April 6) is able to be about.

## ABOUT HYDROPHOBIA (LYSSA. RABIESCANINA.)

BY A. SCHMID, M. D. MICHIGAN CITY, IND.

1. *Literature*.—Layard—Experiments with the Poison of Mad Dogs, from the English; Leipzig, 1778. Vaughn—Cases and Observations on the Hydrophobia; London, 1779. Mederer—Syntagma de Rabie Canina; Frib., Brisgau, 1783. Zinke—New Views about Hydrophobia, its Causes and Consequence; Fena, 1804. De Saint-Martin—Monography of Hydrophobia. Translated by Fitzler; Ilmenaw, 1824. Lenhosseck—About Hydrophobia; Pesth, 1837. Berndt—New Experience and Experiments with Inoculation for the Eludication of Hydrophobia; *Hufeland's Journal*, 1834. Textor—Hydrophobia; *Henke's Monthly*, 1843. Astfalk—De Hydrophobia sede ac Natura; Halis, 1847. Blaine's Canine Pathology, fifth edition, by Walton Meyer; London, 1851. Youatt—The Dog; Stuttgart, 1852. Etc., Etc.

Since the new method of curing this dreadful disease, hydrophobia, by Prof. Pasteur, in Paris, attracts as much attention in the medical world as among the public in general, I beg leave to publish a cure which is as simple as efficient.

2. *Facts*.—The symptomatology of this disease presents differences according to race, individual, and the general constitution of the patient, so that formerly two different forms were believed to exist. In this disease there are principally two stages, the prodromic and that of irritation. The autopsy of the corpse does not give much information about the nature of the disease. But that Prof. Pasteur's cure is not a new one can be proved by the experiments of inoculation made by Gruner and a Count Salm Reiferscheid in 1813. The Aetiology of the lyssa traumatica seems to show clearly that the poison of a mad dog acts like a ferment. In regard to the effects on the nervous system

the most remarkable chronic form of alcohol poisoning seems to present the most analogies.

3. *Treatment of such wounds.*—After the fresh wounds, which usually heal without difficulty, are cleaned with a wash of equal parts of tincture arnica and water, I put one or two cups on it and apply compresses of this wash. Formerly the wounds were burnt out with hot irons and afterwards\* caustics were used, but I would employ these only in extreme cases.

4. *Psychical treatment of the patient.*—It is one of the most important duties of the physician to convince the patient of the efficacy of his treatment, inasmuch as the fancy in this disease is so occupied that the greatest excitement is followed by the most profound dejection or despondency, by which, without any real danger death may be caused. In most cases it will suffice to give the patient the assurance of the success of the treatment, and the physician must even in some cases accede to the prejudice of the patient in order to use this in the removal of his apprehension.

5. *My treatment.*—When called to a patient of this kind I examine and clean the wound carefully, using at the same time one or two cups and give ever half hour a powder of 0.1 to 0.5 grammes for five hours, after that every hour for three to seven days according to circumstances. This powder, prepared after an old recipe:\*

R. Conche præp.,	20 parts.
Radix gentianæ,	20 “
Bolus (red),	10 “
Myrchæ gummi,	6 “

\*See Virchow Handbook, 1855; Vol. II., p. 348.

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## TRICHINA SPIRALIS.

BY C. DU HADWAY, M. D., JERSEYVILLE, ILL.

*Trichina Spiralis* was first discovered by Tiedman in 1822; by Hilton in 1832; by Paget and Owen in 1835, since which time the dissecting room has furnished specimens of this parasite for the observer's investigation, About that time these worms were supposed to be harmless, but Zenker of Dresden demonstrated that while a few might be harmless, yet they are capa-

ble, and do produce serious disease and destroy life. This affection is called *Trichinous* or *Trichinosis*. It has been recognized in Germany since 1860. In a Prussian town, during the year 1863, of a population of about 103 inhabitants, nearly all became sick, and in fact several died, caused by eating sausage made from diseased hogs.

Another outbreak occurred in 1865 at Hedersleben, causing forty deaths out of three hundred cases. The first cases in America occurred in New York and were reported by Dr. Schnetter. In 1866 at Marion, Iowa, of a family of nine, five died under the care of Dr. J. H. Wilson. Of the same county in Iowa, Dr. Restine reported six cases from eating raw ham. Microscopists, as a rule, find *trichina* in two out of every fifty hogs that are packed, and some of their muscles contain from 10,000 to 18,000 to the cubic inch. Such animals as these are not always out of health. The worm is not visible to the naked eye. The *trichina* is a bi-sexual worm, reproducing in the stomach and intestines of animals and men. Their offspring then finding their way through the walls of these organs, finally become encysted in the muscles. In 1875 a disease usually denominated *hog cholera* was raging to a great extent in Jersey County, Illinois, as well as in the adjoining counties. It seemed that very little was known about the origin and cause of this disease, so-called *hog cholera*.

On account of a failure on the part of those who had attempted to investigate the pathology of this epidemic, I became interested in the matter, and for six or eight weeks I gave all the time I could spare to the investigation of the disease. The results of my investigations were not entirely satisfactory to myself, much less to the public; for until a *specific* is known, and *demonstrated to be a specific*, as a preventive and cure, the public will continue to speculate in their way as to the cause, condition, and cure of *hog cholera*. I only propose to give the results of my experiments at that time. The mortality of hogs at that time in the pens in our city, furnished material and convenience for my work. I think I never saw a finer quality of hogs driven to market than during that season. I put on my old clothes, and with the necessary instruments in hand made my way into the pens. The first dead hog that I came to weighed about

three hundred pounds. I then proceeded to open the hog, and the autopsy revealed congestion of brain, lungs, liver and spinal cord. This hog, as I learned from its owner, had no symptoms of cholera, as it did not purge or vomit. The hog when first notice as being sick was upon its side, seemingly in the midst of a convulsion. I was then prepared to say the hog died of cerebro-spinal meningitis, but upon taking a piece of the tenderloin and a piece of ham to my office and placing it under my microscope, I found *trichinæ* almost innumerable. Then I believed that the congestion of those organs were superinduced by the trichinæ. I dissected hog No. 2, a fine-looking hog, having died the night previous to my examination. The history of the sickness of this one was quite different from the first, inasmuch as this one purged and vomited and did not have convulsions. I found upon examination the stomach, bowels, liver and kidneys in a state of congestion: brain, lungs and spinal cord normal. The microscope did not reveal any trichinæ in this one. I examined seven hogs, five of which I will denominate cholera, and in none of those were there any trichinæ; I found plenty of it in the other two. Not being satisfied to stop my investigations, I thought I would carry them a little further in the following manner: Having procured a yellow dog for the experiment (not because he was better than any other dog, but because I never liked a yellow one), I fed him for a couple of days upon the voluntary muscle obtained from the hogs containing the trichinæ. The result was, in about six days after feeding the meat to the dog he took sick with pain in stomach and bowels, and remained in that condition for about three days, when my patient went into convulsions which ended in death on the tenth day after first notice of illness. Wishing to give the dog the benefit of the doubt, as well as to learn what I could in the post-mortem, I summoned my student to be present at the examination, which was conducted strictly upon scientific principles as well as solemnity. We found congestion of medulla at base of brain, lungs, stomach, bowels and kidneys.

I then fed some of the lean meat from the dog to the chickens (being careful at the time not to let my wife know of my experiments upon that part of her care), and in from one to two weeks, the chickens began to die. I did not know their symp-



toms, whether they had pain or not or vomited, but upon making a microscopical examination I found trichinæ in great numbers. I afterwards examined chickens that died of what is usually called chicken cholera, and failed to find the trichinæ. Having procured a large rat, I killed, skinned and dressed it, and then made an examination and found plenty of trichinæ. I fed the meat of the rat to both dog and fowls, and they died. The worms were found in them. There was one dog, however, that lived after having been sick from eating trichinous meet; but he never recovered his usual health; would eat enough for three or four dogs, and still kept very poor; he would lay and sleep the greater part of the time; finally I gave Mr. H. a dollar to take him out in the country, so I never heard anything further of him. Thus ended by experiments so far as anything like a scientific research. Of the general appearance of the muscles and fat, the muscles affected by trichinæ have a dull, dark color; they do not have that bright red shade peculiar to healthy meat. One who has been accustomed to seeing and handling the hams and shoulders, and especially if they have cut up a great deal of them as they often do in meat markets, can by drawing a sharp knife through the meat feel under the knife a peculiar gritting, as if drawing the knife through fine sand, as the worms cannot be seen by the naked eye; the appearance of the meat as described above and the gritting sensation produced when drawing the knife through are good criterions to be governed by. It requires 176° Fr. to kill these worms, especially when they are coiled in their shells. When out of the shell and in a migratory condition, it takes 150° Fr. to kill them. The appearance of the fat while in the hog, is of a light salmon color, that is owing to the retention and diffusion of bile, but nothing short of a microscopical examination gives positive information. The butchers may kill a hog that is full of trichinæ and very innocently sell it to their customers. In this case as in all other diseases there is a period of incubation; the hog may have been killed during that time, and before the worm had made inroads sufficient to show illness of the hog. Salting and smoking meat does not kill the parasite; they seem to thrive, multiply, and develop in that condition. Hog cholera does not exist in any country where there are no rivers to navigate, or railroads to

carry rats and distribute through the country. Such a thing as *trichina* was never known until the wharf-rat was introduced into the country.

I know of no preventive or cure. It matters not what a hog dies of nowadays, it is a case of cholera. There is a vast deal of difference between *trichinosis*, *cholera* and *pneumonia*. The hog when affected with *trichina* is stiff, and you can see by his actions that he is in pain; convulsions close the scene and death is the result. In *pneumonia* the hog coughs, sneezes, has fever, and his breathing is of a wheezing character, as though they had *phthisic*. This is owing to the congestion and infiltration of the lungs. *Cholera* is distinguished from *trichina* and pneumonia by the purging and vomiting. I have already intimated how it is possible for hogs to contract *trichinous* disease. Now I will tell you how it is possible for hogs to contract pneumonia. In Jersey County, and I presume through the entire country those who raise hogs care for them as to shelter, by making their nests large enough to accommodate as many as wish to nest together. I have seen as many as twelve hogs, any one of which would weigh two hundred pounds, come out of a nest under a straw-stack where they had rested all night. In the morning when the mercury was standing 12° below zero, they came out to be fed and watered. They came out all in perspiration, and you could see them in less than three minutes after reaching the cold air begin to sneeze and cough. It is no wonder they took pneumonia after having been huddled up together, breathing one another's breath and steam from night until morning. A hog that had *trichina* is liable to have sores on him. I have seen hogs with abscesses as large as your fist in their hams. Diseased pork is an evidence of unhealthy meat and should never be eaten. A hog may have had *trichina* and partly recovered, but that hog will never thrive like healthy ones, and it is not a hog to be used by any one for anything.

I would suggest, for the benefit of the butcher, packer and the people that a man competent in each place where pork is killed, be appointed to make such examination, then there would be no such thing as butcher, or those who consume the meat being deceived. And until something of the kind is done, those risks will have to be taken.

## SOCIETY TRANSACTIONS.

## PEORIA ACADEMY OF MEDICINE.

Meeting of March 1, 1886. J. S. Miller, M.D., President.  
J. H. Coulter, M.D., Secretary.

Dr. H. KRUSE read an interesting and instructive paper on

## BLENORRHOEA NEONATORUM.

This blenorrhœa, or purulent conjunctivitis, is the most frequent both to specialist and general practitioner. It is the most destructive, and most frequent cause of blindness. Is blenorrhœa neonatorum from its inception such a malignant disease, or has carelessness and ignorance much to do with the result as shown by statistics? I think it is in a great measure due to the latter, and that rational and careful treatment in the first stage will give almost certainly good results. The severest cases are those which come from the infection of acute gonorrhœa. The progress of these cases is so rapid, and the physician usually called so late that destruction of the eye or eyes is unavoidable. It is contagious, and most frequently comes from pathological secretions from the genitals of the mother. Infection may take place during birth or afterwards through carelessness of the attendant. It is possible that a predisposition exists in some eyes to contract the disease. It may also in some cases result differently, in one producing only a catarrhal, while in another a purulent conjunctivitis. The catarrhal is often aggravated to the purulent by the use of the most absurd and filthy remedies, which necessarily tend to make the case so much more serious.

The symptoms of blenorrhœa neonatorum are, in the first stage, those of a simple catarrhal conjunctivitis, hyperæmia, slight swelling of the lids (which are often glued together), the lachrymal secretions increased. The morbid secretions at this stage seem like particles of mucous floating in the transparent tears. The secretion gradually becomes more turbid and milky, soon giving place to a copious discharge of cream-like, white, yellow, or greenish pus. The discharge does not now glue the lids together, but a copious purulent secretion oozes out between the lids, small streams constantly run down the face often producing

an erythema or even eczema or excoriations. The swelling of the lids now becomes very prominent especially of the upper one, sometimes completely covering the lower one. This is usually the stage in which the physician first gets a chance at the eyes, the parents before supposing it to be but trifling. The mucous membrane is now of a uniformly darker color, the blood vessels being completely lost in the intense hyperæmia. The surface appears granular from the enlarged papillæ. By everting the lids the folds of the swollen conjunctiva will present themselves as large tumors. Sometimes the conjunctival bulbi will be so enlarged from serous infiltration, forming an elevated wall, that a full view of the cornea will be obstructed.

Corneal affections may now occur, and herein lies the great danger of the disease. The affections vary from slight epithelia losses to purulent infiltration of the whole tissue. These cases will each have a corresponding result, from a transparent cornea to prolapsus iridis, staphyloma, etc. I will now relate several cases which occurred recently in my own practice.

*Case 1.*—I was requested to call to see a case of ophthalmia at — W. Madison street. On arriving I found the patient, nine days old, suffering from a most aggravated case of blenorrhœa. The affection had commenced the second day after birth, and had been without medical treatment thus far. The attending midwife had taken charge of the case, telling the mother it would not be necessary to call a doctor. The seventh day after the affection commenced, the parents becoming alarmed sent for Dr. T., who referred them to me. After cleaning the eyes of the copious purulent discharge, I opened them and found, what I expected and feared, both cornea totally destroyed.

*Case 2.*—A few days after, Mr. L., a farmer from Lincoln, called at my office with two of his children. The one an infant five weeks old, the other a girl ten years old. The baby had been suffering from inflammation of both eyes for nearly five weeks, commencing two days after birth. The condition was almost the same as in case 1, excepting that a small portion of the cornea of the right eye remained, and became transparent under subsequent treatment, and with an iridectomy may possibly restore a little sight.



*Case 3.*—Luia L., the ten year old sister of the infant, became infected one week later, the case being more fortunate as only one of the cornea was perforated, and the cicatrix being on the lower section of the cornea the sight was little impaired. Light macula of the other disappeared under treatment. These two cases had been treated five weeks by a surgeon, who had assured the parents that there was no danger, and they therefore neglected to consult a competent physician in time.

*Case 4.*—A Swiss woman called at my office for the treatment of her three weeks old baby, suffering from bleuorrhœa neonatorum, since the third day after birth. Examination revealed the left cornea totally destroyed, the right cornea had circumscribed infiltration, which healed under treatment, leaving the cornea transparent. The infant died four weeks later from cholera-infantum.

The prognosis in these cases depends entirely on the condition in which we find the cornea; small epithelial losses, or small circumscribed ulcers under right treatment give a favorable prognosis, and likewise does a more serious prognosis come when the ulcer is on the margin of the cornea.

As to the treatment. One remedy is always reliable, and this is nitrate of silver. This acts both as an astringent and a destroyer of the micro-organism. No other remedy can replace it. It has also done more than any other as a prophylactic measure. This consists in instilling a 2% solution into the eyes of the infant after they have been thoroughly cleansed. The treatment in the developed cases requires some dexterity, for the remedy must come in contact with the entire surface of the morbid mucous membrane. Immediately after applying the nitrate of silver, a solution of chloride of sodium is applied to neutralize the excess of silver. Then a gentle stream of warm water is conducted on the conjunctiva to wash off the precipitate. The lids are then inverted and for and for an hour ice-cold applications are applied every five minutes. This operation must be repeated every twelve to twenty-four hours, as the severity of the case may require. So long as the discharge is very copious the eyes must be cleaned every half hour. This is best done with bits of absorbent cotton saturated with boric acid. On the care and precision with which this treatment is followed, as much depends

as on the use of the remedy itself. My plan is to apply the nitrate of silver as early as possible. Some physicians, however, will use ice or scarification during the acute stage. The strength of the solution to be applied is 10 grains to the ounce, except in very obstinate cases when I increase it to 15.

It sometimes happens that the upper lid is so much swollen that eversion is impossible. Then the external canthus must be divided. The bleeding caused by this operation has at the same time the beneficial effect of the scorifications. If the cornea is effected instillations of eserine are of great benefit—a solution of one grain to three drachms. Keratitis must be treated according to the form in which it presents itself.

*Discussion.* DR. DOMBROWSKI:

I think a 2% solution of silver nitrate should be the weakest used. It is better at the same time to use an atropia solution, 10 grains to the ounce. I have applied an ice-bag for one day and then used the silver nitrate with the best of results. Some use a watch glass over which they brush iodoform to protect the other eye; some say bandage the arms and do not cover the eye. It is necessary to draw a line between catarrhal and purulent conjunctivitis. Purulent is always followed by discharge and always depends on a micro-organism, and this micro-organism is found only in the cervix uteri, not in the vagina. It can also be found in the eye discharges.

DR. MACLAY: I have seen almost one thousand infants born, and have never yet seen disastrous results follow. Two reasons, I think, contribute principally to this. It has been a country practice, and also I have always been very careful to see that the eyes were thoroughly cleansed immediately after birth. For this nothing is better than a soft cloth and a mild soap.

DR. WILL: In a practice in the country extending over a number of years have attended a like number of births. During that time I have seen but two cases of blenorrhœa neonatorum, and yet in my first years' practice in the city saw a like number. From these cases and the circumstances I am led to believe it is largely due to gonorrhœa. I consider the prophylactic treatment especially practical as well as important in the suspected cases.

DR. KRUSE, in closing said: I would not bandage the other eye, for we could not then be sure that it was not effected. In

the cases referred to by my paper I am positive there was no gonorrhœa present, but that it must be a highly contagious disease is likewise very apparent. The micro-organism has been discovered in the simple vaginitis of little girls. When the purulent stage appears the only thing then is the nitrate of silver, and it should not be used weaker than 10 grains to the ounce.

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### CORRESPONDENCE.

#### RHEUMATIC AFFECTIONS OF THE EYE.

DECATUR, ILL., April, 1886.

*Editor Peoria Medical Monthly:*

I noticed Dr. Walker's inquiry in regard to a decision of the pension office denying that rheumatic inflammation of an eye can make blindness, and I refrained from answering because I hoped some one else would do so. I certainly think such a decision by that office is a very silly and unscientific one, and on a par with some other decisions I have known to issue from that office. From an experience of one year, as Secretary of the Board of Pension Examiners of this county, I became convinced that none of the medical gentleman in that office were acquainted with ophthalmology or otology. Men who claimed pensions because they could not see as well as they should, and upon whose cases our board reported finding simple hypermetropia, which when corrected gave normal vision, were by these sapient medical men in the pension office allowed to go before another board not conversant with these matters, and secure a pension on their report that the party had defective vision. The service had quite as much effect in producing these cases as the moon had, not one whit more.

It might be pertinent to inquire what these gentlemen are in the pension office for, if it is not to detect the falsity of such claims? And the statement which Dr. Walker refers to indicates great ignorance of the subject on their part, because there is little reason to doubt that the rheumatic diathesis, in which imperfectly metamorphosed products of digestion circulate in the blood, is quite as capable of inciting inflammation of some of the ocular tissues, as of other portions of the body. No doubt many

cases of iritis called rheumatic, are syphilitic in origin, but all are not. The fact as to blindness, seems to be that the pension office should care for, and evidence that it had not been preceded by sphyilis, if, as I believe is the case, the law does not permit them to grant a pension where the disability is shown to be of that nature. If the pension authorities do not know enough to see the necessity for an oculist and aurist upon the examining boards whenever it can be accomplished, they should at least see to it that one or two are employed in the office at Washington, when it would be easy to detect these cases.

I certainly must answer Dr. Walker's question in the affirmative: that rheumatic inflammation of the iris can cause blindness.

S. J. BUMSTEAD.

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## PERISCOPE AND ABSTRACT.

### CORYZA AND CONJUNCTIVITIS.

The term catarrh is commonly used to denote an inflammation of the mucous membrane which has been produced by the action of cold. The expression, coryza, is generally used to designate an inflammation involving the mucous membrane of the nasal passage. At the commencement of the attack, there is generally a feeling of malaise; the sensation of a cool breeze on the back, with chilliness, frontal headache, and a heaviness in the same region. Following this there is a discharge from the nostrils and a suffused condition of the eyes.

This congestion of the conjunctiva, although practically a catarrhal condition, is, if we are strict in our nomenclature, simply a reflex inflammation. If you pass a probe into the nostril and touch the mucous membrane at different points, you will find, in nearly all cases, the following symptoms developed: increased secretion of tears and a congested condition of the conjunctiva. This signifies that an irritation of the mucous membrane of the nose may cause a congestion of the conjunctiva.

The inflamed condition of the Schneiderian membrane in coryza acts as the irritant that produces the congestion of the conjunctiva. Whether the vascularization of the mucous membrane of the eye is produced by a correlated wave-dilation of the blood-vessels in the conjunctiva through the ganglia, or a reflex action through the brain, suspending the inhibitory power of the vaso-motor nerves, will make no difference in the treatment. In



these cases it is evident that the cause is located in the nose and consists of an inflammation of its lining membrane.

There are two kinds of glands in this structure—the mucous and the serous. The latter are the more numerous and also the larger. The mucous membrane of the nose is not uniformly the same, but is different in the “olfactory region,” from what it is in the respiratory region. “Its epithelium is covered on the free surface with the membrana limitans externa of V. Brunn, through the holes of which projects a portion of the olfactory cells of Max Schultze.” The outer process of the olfactory cells extends through these openings beyond the common surface, either as a single minute rod, or as a delicate bundle of cilia. The follicular and racemose glands lubricate this membrane by pouring upon its surface a clear mucus.

The first effect of irritation is contraction, which is soon followed by dilatation of the arteries and then of the veins. The circulation is accelerated and the surface is dry. However, in a short space of time the current is retarded, and, at the same time, the leucocytes increase in the part, becoming attached to the walls of the veins, lessening their lumen. This increases the hydrostatic power in the inflamed area, so that the exudation of liquor sanguinis is favored or enhanced. Concomitant with this we have the migration of leucocytes.

In coryza the greater portion of the fluid is poured out upon the free surface and escapes. A portion, however, is infiltrated in the connective tissue, and from this we have the swelling of the membrane. The infiltration and tumefaction may be so decided that it will occlude the passages and respiration will have to be performed through the mouth. As a general rule, but one nostril is occluded at a time, while the other one remains open or patulous, so that the air will pass through it.

In the treatment, attention must be given to the coryza first. If there is much mucus covering the inflamed membrane of the nose, it is necessary for this to be removed, otherwise the remedy will be expended in coagulating the mucus, and not have any effect on the membrane itself. One of the best solutions for cleansing the throat and nasal passages is Dobell's, which is composed as follows:

R.	Acidi carbolici,		12 grs.	
	Sodæ biboratis,			
	Sodæ bicarbonatis,	aa	20 grs	
	Glycerinæ,		1 oz.	
	Aquæ,		ad 8 ozs.	M.

This can be used as a gargle in the throat, but should be sprayed on the nasal mucous membrane with an atomizer. Afterwards various applications can be used.

One of the best prescriptions to allay the irritation and sneezing and check the discharge, is composed of the following ingredients:

R.	Morphiæ sulphatis,	3 gr.	
	Pulveris acaciæ,	$\frac{1}{2}$ dr.	
	Bismuth subcarbonatis,	1 dr.	M.

After cleansing the parts with Dobell's or some similar solution, this powder can be snuffed up the nostrils. However, it can be used without any previous cleansing of the parts, and will be found to give almost immediate relief from the above symptoms.

An attack of acute coryza may often be aborted by giving from six to ten grains of sulphate of quinaë, together with hot pediluvia and a hot lemonade just before retiring for the night. The object is to stimulate the sudoriferous glands and restore the proper harmony between heat-production and heat-waste. A full dose of Dover's powder, (ten grains to an adult), will relieve pain, if any exists, and produce diaphoresis. Other remedies that sometimes used for the same purpose, are, carbonate of ammonia, ten to twenty grains; chloride of ammonia, thirty grains; solution of the acetate of ammonia, one ounce; tincture of belladonna, twenty minims. A very good way to relieve the unpleasant, "stuffed up" sensation in the nose is to take a drachm of pulverized gum camphor, put it in a quart of boiling water and inhale the steam through the nostrils.

A large number of remedies have been used by inhalation. Hager's remedy for a cold is composed as follows:

R.	Ac. carbolic,	4 parts.	
	Spts. rect. fort.,	12 parts.	
	Liq. ammon.,	4 parts.	
	Aq. dest.,	8 parts.	M.

SIG.—A few drops to be put on cotton, or a piece of sponge, in a tube and the air inhaled through it, or a small amount can be dropped upon a handkerchief and inhaled four or five times a day.

If the congestion of the conjunctiva is quite marked, the following prescription will be beneficial:

R.	Morph. sulph.,	2 grs.	
	Ac. boric,	12 grs.	
	Aq. rosæ,	1 oz.	M.

SIG.—Three drops in the eyes from three to five times a day.

Occasionally, as the result of violent sneezing, a small blood-vessel will be ruptured in the ocular conjunctiva. These conjunctival ecchymoses are sometimes very unsightly. They gen-

erally disappear without any medical aid, but the absorption may be quite slow and protracted. Nature always makes an effort to throw off an abnormality of interference with the work. Probably the best treatment is a compress and bandage. The compress may be saturated with a solution of tincture of arnica, one drachm to a gill of water. Pressure is the most important object in this condition. It not only tends to prevent the increase or spreading of the extravasation, but to hasten its absorption.

Some of the old empirical remedies for the cure of a "black eye," such as the application of a rotten apple, of a raw oyster, of a piece of raw meat and numerous other substances, depend for their curative powers upon the pressure of the bandage that is used to keep them in position, aided, perhaps, by the moisture.

In some of these cases there is a relaxed condition of the conjunctiva, the blood-vessels being large and full, with a very marked degree of lachrymation. This free secretion of tears is due, primarily, to the reflex irritation from the mucous membrane of the nose, and secondarily, from the conjunctiva. In these relaxed conditions of the conjunctiva, a solution of tannic acid, two or three grains to the ounce of water, acts very well. Alum and zinci sulph. combined in solution is a good preparation. Ferric-alum answers very well in certain conditions.—*W. R. Amick, M.D., in Lancet and Clinic.*

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## INJECTIONS OF OIL OF TURPENTINE FOR THE RADICAL CURE OF FISTULÆ.

Cecchini has employed oil of turpentine with good results in the treatment of several varieties of fistulæ. He claims that this substance acts as a powerful antiseptic, produces granulation, and can never do harm if a reasonable amount of care is exercised.

1. *Fistulæ in Ano.*—Seven cases treated, with five cures. The turpentine was injected by means of a syringe. As it causes considerable pain, it may be diluted with almond or olive oil. Short fistulæ are most easily cured by this remedy.

2. *Caries of petrous portion of temporal bone.*—Four cases cured in from two to three months. Boracic acid was used in conjunction with the turpentine. The discharge of fetid pus soon ceased, and complete cure rapidly followed.

3. *Dental fistulæ.*—Eight fistulæ, with caries of alveolar process and maxillaries, were completely cured.

4. *Fistulæ of Steno's duct.*—The fistulæ treated was caused by an abscess following a gun-shot wound. From the parotid region, fistulæ extended into the cheek, angle of jaw and neck.

During mastication saliva flowed through the opening in the cheek. The fistula was healed in thirty days, with six injections.

Cecchini has also employed turpentine in the treatment of carbuncles and in post-mortem wounds, in every case with excellent results.—*Centralblatt für Chirurgie*.

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### VESICAL TUBERCULOSIS.

In a letter from Paris to the *N. O. Medical and Surgical Journal* there is a translation of a clinical lecture on the above subject by Prof. Guyon, in which is found the following history of a case bearing upon the diagnosis of the malady:

“He is a young man, twenty-four years old, without pathological antecedents or history of gonorrhœa. I might also add that at the time he felt the first symptoms of his affection, he had never yet had sexual intercourse, thus excluding entirely any local infection through contagion. He felt the first pain whilst a soldier, which proves that up to that time he enjoyed sound health. He first experienced a frequent desire to urinate. He entered the hospital where the silver sounds were introduced into the bladder. The pains only increased during micturition, reaching their maximum at the end, but were prolonged for a good while after emptying the bladder. At a certain time his affliction was such as to force him to rise from fifteen to twenty times through the night to urinate.

“A strong solution of nitrate of silver was then injected into the bladder, but the result of this was a daily increase of pain, whilst the general condition of the patient grew worse, and so painful were the spasms that at each micturition it would seem as if the whole length of his urethra was being incised.

“I saw the patient in the beginning of the year, and by the judicious use of morphine I succeeded in quieting the pains so well as to allow him to leave the hospital. Unfortunately this calm was short, and after a few ups and downs he has come back to me requesting the operation of cystotomy, the availability of which I had already hinted to him. Such is the information I can give you about this patient, which warrants me in diagnosing tuberculosis, though I admit the diagnosis is not absolute, and that there are certain reasons why it should be somewhat reserved. It would appear that the tuberculosis is entirely limited to the bladder; no traces are to be found elsewhere; the testicle and seminal vesicles do not reveal the presence of any suspicious nodosity; nor does the prostate seem affected, an organ to which great attention is directed in such cases.



"But any doubt resulting from the examination of the patient disappears when the clinical course of the disease is studied. Of all the symptoms enumerated above, it is true that none is pathognomonic, but their concurrence has the greatest significance. Such accidents appearing without gonorrhœa, stricture, traumatism, or foreign body in the bladder, without affection of the kidneys, in a word without any of the usual causes of cystitis being found in the previous history of the patient, have a most important clinical meaning.

"Spontaneous cystitis may be ranked with spontaneous bronchitis, and the physician should entertain the same fears for both. This consideration has still more weight when the cystitis apparently without any special cause has resisted all rational treatment, like certain intractable cases of bronchitis. Such elements are almost sufficient to diagnosticate tuberculosis, though I have not yet mentioned one of the most important symptoms of vesical tuberculosis, hematuria. It is especially significant when early in the case. Just as in pulmonary tuberculosis without determining a positive tubercularization of the organ, hæmoptisis is very suspicious, so hematuria brings the suspicion upon the bladder, especially when it occurs spontaneously and at a time when organic lesions are not pronounced.

"The careful examination of the urine is another sign not to be neglected. This examination has revealed in the middle of numerous epithelial cells and among bacteria of ammoniacal fermentation, many bacilli of tuberculosis. The result of this examination was sufficient to cancel all doubts if any were left, so that we positively have to deal with a case of tuberculous cystitis."

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### TREATMENT OF COLLES' FRACTURE.

In an article by Dr. H. P. Cooper, of Atlanta, Ga., on the treatment of fracture, published in the *Atlanta Medical and Surgical Journal*, the following is given as the best means of treating the above:

I am convinced that immediate reduction lessens the subsequent inflammation, and as a consequence less adhesion takes place between the tendons and their sheaths. In reducing the fracture, we should bear in mind the position that the fragments occupy and the nature of the obstacle to be overcome. The lower fragment is displaced backward, its lower end at the same time being tilted slightly upward. The posterior border of the upper fragment is more or less impacted into the cancellous structure of the lower fragment. Hence our first effort should be to dis-

entangle the fragments. This is best done as follows: Grasp patient's hand firmly, as if you would shake hands with him; the other hand is placed over the patient's wrist so that the thumb lies over the posterior aspect of the lower fragment, while the fingers lie over the anterior aspect of the upper fragment. While an assistant steadies the forearm, you carry the hand strongly backward—*i. e.*, produce hyper-extension in order to disengage the upper from the cancellous tissue of the lower. As soon as this is done, press the lower fragment forward with the thumb, counter-pressure being made by the fingers on the upper fragment. Simultaneously with this pressure, carry the hand rapidly into flexion, at the same time bearing towards the ulnar side, and the fracture is reduced. The ease with which reduction is accomplished by this method of hyper-extension will astonish any one who has struggled in vain to effect it by simple traction and pressure.

If then the deformity is entirely overcome, we are ready to apply the splint. This is fixed in position by two bands of rubber plaster one inch wide, one band being passed around the forearm and splint just below the elbow, the other band surrounding the lower end of the splint and passing directly over the posterior aspect of the lower fragment. The compress which has been fastened to the splint lies just at the lower end of the upper fragment, and by means of this compress and the lower band of plaster, pressure and counter-pressure are furnished to any degree needed, and a reproduction of the deformity is impossible. I should remark that no bandage is applied to the hand or forearm underneath the splint. A bandage, however, is applied *over* the splint from hand to elbow. The forearm is then put in a sling in a position of semi-pronation, the hand hanging free from the sling and not supported by it; this takes advantage of the weight of the hand to prevent deflection towards the radial side. If, however, this radial deflection cannot be entirely overcome, the lower end of the splint may be prolonged as the common pistol-splint, and the hand attached to this by plaster.

As a rule the splint can be removed on the 21st day; passive motion can be cautiously commenced at the end of two and a half weeks, and is to be done without removing the splint.

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## SOCIETY REPORTS AND MEDICAL JOURNALS.

For some time the *St. Louis Medical Journal* has published a verbatim report of the proceedings of the St. Louis Medical Society. Finally it concluded that such extended reports were

not pleasing to its subscribers, and hence that its extra expenditure in the procuring of such elaborate reports was actually detrimental to its financial interests. With this view of the matter, it discontinued these reports, publishing such portions as it thought would be interesting to its real or desired readers.

On the other hand, the St. Louis Medical Society passed a resolution prohibiting the publication of its transactions, or any portion thereof, in any medical journal. It further ordered that no member or visitor should transcribe its proceedings in whole or part, or publish any condensation of the same.

Had its members reflected for a moment they would have seen the absurdity of any such resolutions, to say nothing of their futility. They may be assured if they include among their number any live editor he is sure to obtain all that is really of interest to the profession outside of St. Louis. Such matter has a positive value to a medical journal, because it interests its readers. To it all else is trash. To it all else published serves simply as a mill-stone to drag it to perdition.

If they reflect farther they will be convinced that the great mass of what is said in medical society meetings, both as to style and to matter, is simply trash to all outside of the immediate listeners, and generally to these also. By courtesy physicians listen to long-winded speeches, which have no point farther than to kill time. Generally a twenty minutes' speech can be compressed within ten lines.

Farther reflection will convince the thoughtful members of any medical society that their own professional reputations will be most surely advanced among the journal reading public by having their speeches condensed to the utmost possible, so that all may be induced to read them, and, better still, remember the points made by each speaker.

If the time ever was that working men could live on wind, it has long since passed by. Substantial food attractively prepared is what is called for by the readers of medical journals of the present day. A medical society that attempts to feed medical men, should welcome the pruning of the accomplished, wide-awake editor, in order that they might be so trained as to be able to acceptably instruct the medical public.

Medical editors are a long suffering folk. They receive and publish a vast amount of rubbish, in their efforts to educate men to write properly. But there comes a limit to their endurance occasionally. Still their interests and those of the societies whose proceedings they report are identical, and it is a pity for all that any difference or antagonism should arise. Let all societies see to it that all their discussions and papers are as con-



densed as is consistent with clearness, and there will be no hesitation on the part of medical journals in publishing the same.—*American Lancet*.

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### CASE-BOOK.

Under the above title Dr. Kirk in the *Georgia Eclectic Medical Journal* gives the following account of his somewhat unique business methods:

We should not stop at facts and practice, but extend our articles to the more interesting part of the profession—the financial part; at least, we should know our patrons and our business, and as collecting is indispensable, have it well in hand. The country or village doctor must turn to another calling occasionally to facilitate his collections. A good collector is, generally, a safe physician. He don't practice much "bosh," and, as he expects to do his duty in collecting, he will not want any such objections to his bills as, "You didn't come when I sent for you;" "You were too slow to give relief, and save my child;" and "I would just as soon have no doctor anyway as to send for him one day and have him come poking up next day." And, as I have intimated in former articles in this journal, do your whole duty as physician to the sick; make your charges reasonable and correct, present them in due time and in a business way, so as to let them know that the practice is a business and must be so considered. I generally class my patrons as paymasters; from some I only expect work or trade, whilst others are counted as cash. I generally sort out a parcel who can only pay their bills in cattle, and others who can only pay by driving cattle, and by combining the two a car load or two of beef cattle are collected and shipped to New Orleans, where the cash is at hand—a sum ranging from two to four hundred dollars—which is by no means a dishonor. The poor man has paid for his practice, the doctor is benefitted, and that without omitting practice for a single day, unless he wants to rest by traveling, and makes the trip with his cattle. We need not expect cash from every man, but very nearly every man can pay his bills in some way or another, if the doctor will arrange his patrons and his business so as to utilize the products of the country, without waiting for it to be handled by the "middle man." But this thing of collecting often requires good thought, and as methodically arranged, as does any part of the doctor's practice, and, without due attention, will soon prepare the M. D. to move his location. Here, in Mississippi, the law exempts more than a majority have; be-



sides, the "fellow" can bargain and sell to his wife or other parties, so as to prevent the collection of debts by execution. This is all very good, perhaps; but the doctor must expect to collect without any assistance from the law, and, therefore, good brain work is as necessary to collect as to practice successfully.

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### IN INFANTILE PARALYSIS.

In the *N. Y. Medical Journal*, Dr. V. P. Gibney has an interesting article read before the Clinical Society on the subject of "Limitation of Therapeutics in Infantile Paralysis," from which we extract the following paragraph or two:

What can be done to prevent the subluxations and deformities which arise from muscular and tendinous shortening?

Without citing other cases, I may use the one already presented. We agreed upon keeping the limb and joints in normal position by means of light apparatus, and I am assured that there has been neither relaxation of ligament nor contraction of tendons.

For instance, it was directed that the hips should not be permitted to occupy long a position of flexion or adduction or abduction, and that at no time should superextension be allowed. The child could sit in a wheel-chair, provided the feet were maintained at a right angle with the leg. It was understood that under no circumstances should superextension of the knees be permitted. The feet were to be held at right angles with the leg when the child was out of the chair.

The case was kept under pretty close observation, in order that any tendency of the flexor muscles to contract should be promptly met by apparatus.

To summarize:

1. Avoid any undue stretching of the fibrous structures of the joint.
  2. Do not permit long-maintained positions of the parts by which muscles whose function has not been destroyed can become shortened.
  3. Apply corrective apparatus when it is necessary to oppose contraction.
  4. It is better not to leave these observations to the family.
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Subscribe for the PEORIA MEDICAL MONTHLY—a practitioner's journal.

## DIPHThERIA; CROUP; O'DWYER'S METHOD; RECOVERY.

The following is the report of a case occurring in the practice of Dr. R. N. Disbrow, of this city:

The patient, a child two years and nine months old, was seen by the doctor for the first time on March 8, 1886. The pharynx was covered with diphtheritic exudate, the cough was slightly croupy, and the general condition was poor. At that time she had been ill five days; "started to lay around and got feverish."

*March 9th.*—Croup well marked; there are croupy cough, croupy inspiration and expiration, and she has been restless and sleepless all night. At 2 P. M. I saw the case with Dr. Disbrow. The child's complexion was of a dull pale color, but respiration was loud and hoarse, the cough hard and croupy, and her voice entirely gone. She was very restless, turning over and over on the bed, making it impossible to keep her covered, throwing her arms and tearing at the clothes about her neck. There was marked recession of the chest-walls on inspiration. On auscultation, no vesicular breathing could be heard over the back. On examining the throat, the slightest embarrassment to breathing brought on deep cyanosis. The entire pharynx was covered with diphtheritic exudate; there were also patches on the tongue and lips. Besides internal remedies, steam had been thoroughly tried, and at the time slaking lime was doing its best.

The doctor advised surgical interference, but the parents positively declined. They had known of a case of tracheotomy, and would not consent. He then represented to them the gravity of the case, and repeatedly assured them there would be "no ether, no cutting, no blood." They consented, and at 4 P. M., in the presence of Dr. Disbrow, Dr. O'Dwyer, and Dr. Booth, I inserted a tube estimated to be of the proper size for a three-year-old child.

The usual method of inserting the tube is as follows: Wrap the child in a blanket, set it up straight on a nurse's lap squarely facing the operator, and insert the mouth-gag, having a third person steady the head. With the left index-finger hook up the epiglottis and with the right hand insert the tube by means of a holder, and detach it. When assured that it is in the larynx and not in the œsophagus, withdraw the thread and wait.

In this case the insertion required about five seconds. The child looked bewildered, began to swallow, loose mucus rattled and provoked moderate cough, and the child's color changed from dusky to clear. In ten minutes she was sleeping in bed so quietly that her respiration was inaudible at a distance of two

feet. Having relieved the laryngeal obstruction, we all went home, leaving an unpromising case in the hands of an old man as nurse. At 8 P. M., the child was given some milk, which she swallowed with difficulty—it caused her to cough. She had slept most of the time since 4 o'clock. Temperature 100.5 F., pulse 144, respiration 38.

10th.—She sleeps well, coughs little, and swallows with some difficulty two pints of milk and some beef-tea. Temperature in the rectum 100 F., pulse 144, respiration 36. There is good vesicular breathing over both lungs.

15th.—Vesicular breathing good; pharynx clear of all exudate; general condition good; respiration easy. She coughs more, but swallows much better. The child smiles, and sits up in bed and plays with her toys.

16th.—We had planned to remove the tube, when on our visit it was found that the patient had coughed it out at 4 A. M., just six days and a half from its insertion. Temperature in the rectum 99.5 F., pulse 112, respiration 24, and the general condition good. The nurse said that she swallows better since the tube came away, though she had learned to swallow very well with it in. There is complete aphonia.

26th.—The voice begins to return.

29th.—The child talks and sings—thirteen days after the removal of the tube. She runs about, eats well, and has no paralysis.

During the recovery of this patient, a baby, eighteen months old, in the same family, sickened with diphtheria (nasopharyngeal) and died.—*Wm. P. Northrup, M. D., in N. Y. Medical Journal.*

## A NEW ASPECT OF INFLAMMATION.

Dr. J. B. Sutton in his Erasmus Wilson lectures (*British Medical Journal*) argues that inflammation is only a pathological process when it is in process. He shows that the leucocytes are the chief agents in tearing down the tissues as they are in building them up. Tissue waste he regards as an organic process, quite as much as tissue repair. That one form of animal lives on another and lower form is a physiological axiom.

Metschnikoff has lately shown that the digestive property of cells is not confined to nutritive purposes, but also plays a part in removing larval organs and foetal relics and protects the organism from deleterious substances. Leucocytes fuse to form large protoplasmic masses. Fragments of nerve and muscle are to be found in the protoplasmic masses of the tadpole's tail dur-

ing the process of absorption. In the minute *Daphnia*, the white blood cells are seen to rally round collections of bacteria and to fuse together, if necessary, so as to be able to surround and digest these deleterious organisms. Leucocytes also swarm about any foreign body introduced into a blood-vessel, as though eager to digest it. From facts like these Dr. Sutton has been led to think that inflammation is the method by which an organism attempts to render inert noxious elements whether native or foreign. It is the leucocytes which attack the noxious substances, multiplying, if the latter be in great force, surrounding and digesting them. If the morbid material be too great for complete digestion, both the leucocytes and the patient are in a bad way.

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### CORNING ON LOCAL ANÆSTHESIA.

The author gives a brief summary of what others have done in the production of local anæsthesia by means of the salts of cocaine, and then he adds the results of his own researches. These show that simple arrest of the circulation in the part shortly after the injection of a solution of cocaine suffices to prolong and intensify the anæsthesia.

Farther, if the injection be made after exsanguination and compression there is little diffusion of the anæsthetic, and hence a commensurate diminution in the number of nerve filaments exposed to the influence of the solution. By the aid of massage some purely mechanical diffusion may be produced.

Again, if the injection is made a few moments before exsanguination and the application of the tourniquet a sufficient amount of saturation of the tissue is obtained to expose a large number of nerve filaments to the influence of the anæsthetic.

By this method anæsthesia can be prolonged for any length of time, with comparative small quantities of cocaine.

It is essential in the use of this method to retard or stop the circulation of the affected part during the period required for the anæsthesia. In different portions of the body different forms of compressors are called for. The anæsthetic influence can be made to extend as deep as may be desired. The practical results of this method give great promise that a vast number of operations may be rendered painless without the resort to general anæsthesia.

The work is worthy the careful study of every practical surgeon and physician. It is clearly written, with little useless padding. The author stops when he has said what he wishes.  
—*American Lancet*.



## ULCERATION OF CORNEA.

On January 9th a girl aged three years, was brought to my office, suffering from corneal ulceration. There was intense photophobia, blepharospasm, profuse lachrymation, lids greatly swollen, and the edges raw and bleeding. I could not account for the latter condition until, by questioning the mother, I learned that the child had been complaining of her eyes for several days, and was taken to a woman in the neighborhood who professed to have had extensive experience in treating "sore eyes," especially "wild hairs." This child, she said, had "wild hairs," so she pulled out all the lashes of the right lids at the first sitting, and some from the other lids a few days after. For an application she used a cup of strong tea, in which was dissolved five cents' worth (?) of epsom salts, the eyes to be bathed with this twice a day, and kept to the light as much as possible, so as to hasten a cure. This treatment was carried out with the results as above stated. The mother paid the woman for her services (?). What shall be done with such a woman?

*Locally.*—Frequent bathing with water. Hydrarg. oxid. flav., 5 grains, vaseline 3 drams; applied twice daily, and protection from bright light.

*Internally.*—Syr. ferri iodidi, 5 drops; three times daily.

The case made good recovery. Right cornea showed a slight leucoma; left one normal.—*Dr. Cree, in Amer. Lancet.*

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INVERSION OF THE UTERUS.

Dr. George E. Brickett, of Augusta, Me., reports a case of a woman who, on the third day after labor, had severe expulsive pains, and passed a quantity of blood-clots. From that time she continued to suffer from loss of more or less blood every day, was confined to her bed, became extremely emaciated and anæmic, and could not move without shortness of breath, faintness and vomiting. When Dr. Brickett was called to see the patient, two years later, he found what on first sight seemed to be a polypus, but which a more careful examination showed was the inverted uterus. After a short course of tonic and stimulating treatment repeated attempts were made to reinvert the organ, but these failing, a spring ligature was placed around the base of the tumor, and the uterus dropped off on the tenth day. There was no hemorrhage after the application of the ligature, no severe pain, and no constitutional disturbance. The patient made an excellent recovery, and has enjoyed good health during the seven years that have elapsed since the operation.—*Medical Record.*

## CHLOROFORM AS AN ANÆSTHETIC.

In an account of the recent death of Lady Flora Wilmot from the inhalation of chloroform, for the extraction of a tooth, the *British Medical Journal* says: "The experience of all administrators of repute undoubtedly points to the conclusion that chloroform is not a safe anæsthetic for use with adult patients; and the pages of this journal have for years teemed with instances of death during its administration."—*N. W. Lancet*.

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## RETRACTION OF THE PENIS.

In *Vratch* is reported a case where a man's penis suddenly retracted until it disappeared under the pubic arch leaving a depression something like the umbilicus. When seen by a physician the man had tied a string to the penis, fastening the other end around the thigh. After a few days the organ ceased retracting, the only treatment pursued being the administration of small doses of bromide of potash.—*N. W. Lancet*.

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## TONIC IN PTHISIS.

As a bitter tonic, without wine or alcohol, to induce appetite, Dr. Hudson recommends the following, in *New York Med. Jour.*, known as the "bitter tea" of the late Dr. Tully:

R. Sem. carmi,	$\frac{1}{2}$ ounce.	
Sem. cardamoni,	1 ounce.	
Rad. gentianæ,	2 ounces.	
Cort. aurantii,	4 ounces.	M.

SIG.—Bruise to a coarse powder, place a teaspoonful in a pint of boiling water, and take, cold, a wineglassful before meals.

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## SURGICAL INSOMNIA.

Dr. Henry W. Ridpath uses the following mixture in all cases where the patient cannot sleep or be kept quiet:

R. Sodii brom.,	1 ounce.	
Chloral hydrat.,	2 drams.	
Tinct. digitalis,	$\frac{1}{2}$ dram.	
Aquæ, q. s.,	ad 4 ounces.	M.

SIG.—One to three teaspoonfuls every hour, as needed.—*Medical Advocate*.

# THE PEORIA MEDICAL MONTHLY.

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\*.\*The publication day of this journal is on or about the 25th of each month.

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## EDITORIAL.

### THE ILLINOIS STATE MEDICAL SOCIETY.

The third Tuesday in May is the time set for the annual meeting of our State Society, and the place of meeting this year is the beautiful little city of Bloomington. The easy accessibility of that city should make the attendance large, and very large we hope it will be. The Transactions of the last meeting have not been heard from yet, but we know there is some good reason for it. Still this circumstance again brings up the question of having the minutes and papers published in a journal of wide circulation, instead of waiting a year or nearly a year to get them in book form in which they will only be available to the members of the Society.

Other State societies, as well as the American Medical Association, have adopted this plan, and are satisfied with it.

We hope this question will be brought up at Bloomington, and thoroughly discussed; it will do no harm even if it is not adopted.

Then again the plan of dividing the Society into Sections ought to be discussed, for it really seems as if that would be the only way to secure the needed time for the proper discussion of many of the important papers read.

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### THE BALL THAT WOUNDED HANCOCK.

Dr. Louis W. Reed, of Norristown, thus relates the circumstances of Gen. Hancock's recovery from his wound received at Gettysburg: "I was medical director of the Pennsylvania reserves, and just before the first of November, 1863, I came home on twenty-four hours' leave of absence. I called to see the General, who was in bed at his father's residence. I found him very much disheartened. He had grown thin, and looked pale and emaciated. He said he felt as if he was going to die, and that he had been probed and tortured to such an extent that death would be a relief. I endeavored to cheer him up, and as I was about bidding him farewell he said: 'Good-by, doctor; I may never see you again.'

"I had my hand on the door knob of his chamber when he said: 'See here, doctor, why don't you try to get this ball out? I have had all the reputation in the country at it; now let's have some of the practical.'

"He was lying in the bed with his wounded limb acutely flexed, and all the probing had been done with his leg bent at right angles. The ball had hit him just below the right groin, within an inch of the femoral artery, while he was sitting in the saddle with his legs distended. I went down to my office for a probe with a concealed blade, and on my return Dr. Cooper and myself succeeded in straightening the limb and placing it as near as possible in the position it was when the ball struck him. I inserted the probe and it dropped fully eight inches into the channel and struck the ball, which was imbedded in the sharp bone which you sit upon, called the ischium. In a week's time the General was out on crutches, and in two weeks more he attended a big Masonic gathering at Odd Fellows' hall. I forget the caliber of the bullet, but it was a big Minie ball."—*Philadelphia Times*.



## TO MAKE UP FOR INFANT MORTALITY.

The turbot lays 14,000,000 eggs, well knowing that 13,999,099 will be eaten up in the state of spawn or devoured by enemies in helpless infancy, or drifted out to sea and hopelessly lost, or otherwise somehow unaccounted for. The fewer the casualties to which a race is exposed the smaller the number of eggs or young which it needs to produce in order to cover the necessary losses.

In fish generally it takes at least 100,009 eggs each year to keep up the average of the species. In frogs and other amphibians, a few hundred are amply sufficient. Reptiles often lay a much smaller number. In birds, which hatch their own eggs and feed their young, from ten to two eggs per annum are quite sufficient to replenish the earth. Among mammals, three or at a birth is a rare number, and many of the larger sorts produce one calf or foal at a time only.

In the human race at large, a total of five or six children for each married couple during a whole lifetime makes up sufficiently for infant mortality and all other sources of loss, though among utter savages a far higher rate is usually necessary. Even making allowances for necessary deaths and celibacy, however, I believe that as sanitation improves and needless infant mortality is done away with, the human race will finally come to a state of equilibrium with an average of three children to each household.—*Cornhill Magazine*.

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## DISEASES OF TROTTING-HORSE TRAINERS.

It is a noticeable fact that trotting-horse trainers are as subject to kidney diseases as are railroad conductors. This is caused by the constant jarring of the motion of sulky riding. In the course of a day's training they sometimes ride fifty or sixty miles, and this in time seriously affects the kidneys and other internal organs. Nearly every middle-aged horse-trainer suffers from this complaint, and it carries more of them under their final wire than anything else.—*Chicago News "Rambler."*

Doctors do lots of riding, especially country doctors, and they often suffer from kidney disease, hence the above will apply to them as well as trainers.

## AMERICAN MEDICAL ASSOCIATION.

The following notice from Dr. Atwood calls attention to the near approach of the time for this important meeting. It is unfortunate that St. Louis was chosen as the place of meeting, since the continued labor troubles around and in that city may deter many from attending. We do think there will be any danger of detention or trouble in reaching that city, since the strikes do not affect passenger trains, but only freight.

We hope there will be a very large number present, for this will be the most important meeting of the Association held for many years:

"The rates given to the delegates to the American Medical Association meeting, May 4, in St. Louis, have been fixed by the different railroad committees of the country, at one and one-third fares for the round trip. Delegates must pay full fare coming, and will receive on application, from the agent at starting point, a certificate, which when signed by the Chairman of the Local Committee of Arrangements will entitle them to the reduced return rate.

"No reduced return ticket will be issued unless the purchaser can show a certificate issued by the agent from whom he purchased the going ticket, and signed by the Chairman of the Committee of Arrangements.

"LE GRAND ATWOOD,  
"Chairman Committee of Arrangements."

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NOTES AND COMMENTS.

The beginning of a new volume is a good time to "square up," so we hope about three hundred of our readers will take the hint, and enable us to square up with our printers.

It is claimed upon good authority that when the pulse of the foetus is under 135 in the minute, in all probability it is of the male sex; while when between 135 and 145 it is a female.—*Exchange.*

It is said that adding half a teaspoonful of dilute muriatic acid to a pint of water, mixing this with a quart of milk, and then boiling will produce fine curds as in woman's milk, and will be of pleasant taste.

The galvano-cauterization treatment of diphtheria bids fair to become a most important mode in the therapeutics of this dread affection. It is said to be painless, fever soon disappears, there are no secondary effects, and the operation is easily accomplished. —*Exchange.*

With the present number ends the sixth volume of the MONTHLY. The past year has been a pleasant one in our journalistic life, and the progress made by our journal has been satisfactory. We again return thanks to our readers for their patronage and contributions, and hope that the coming volume will contain even greater evidences of their good will.

When the recent snow storm in Maine was at its worst, one of the selectmen of Limington was told that a neighbor needed medical attention at once. He sent a messenger on foot, the roads being impassable for teams, to the nearest doctor, three miles distant, telling him to stop at all the farm houses on the way and ask the inhabitants to turn out and break roads for the doctor. And they did. The messenger started about 3 o'clock in the morning, and the doctor was able to drive to the patient before noon. If that had been in the West the doctor would have started on foot and not waited nine hours for a chance to ride.

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C. A. JENNINGS, M. D., Triplett, Mo., says: A few weeks since I treated, with success, a very obstinate case of hysteria in a young lady aged 18 years. After going through almost the whole catalogue of "nervines and antispasmodics" with only temporary relief, I became discouraged, but concluded (with very little faith) to try Celerina. After the administration of a few doses the spasms discontinued and in a few days she was up and went to visit her sister several miles in the country.

I HAVE used Peacock's Bromides in my practice with success. A little girl of 12 years had been affected with epilepsy since she was three months old, having epileptic convulsions nearly every day until I put her on Peacock's Bromides. Since then she has not even had a symptom of one. It is surely a great remedy.

JEFFERSON WILCOX, M. D.

Hazelhurst, Ga.

# GUN-SHOT WOUNDS OF THE SMALL INTESTINES.

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By CHARLES T. PARKES, M. D.,

PROFESSOR OF ANATOMY IN RUSH MEDICAL COLLEGE, CHICAGO, ILL.

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*Being the Address of the Chairman of the Section on Surgery  
and Anatomy, read at the meeting of the American Medical  
Association, held in Washington, D. C., May, 1884.*

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## Gun-Shot Wounds of the Small Intestines.

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*Mr. President and Gentlemen of the American Medical Association:* The subject-matter of the remarks to be presented this morning was suggested to me by an article published in the *British Medical Journal* in 1882, from the pen of "that good man among men, and great man among doctors," J. Marion Sims.

The article in question was an appeal for operative interference in penetrating gun-shot wounds of the abdomen, in lieu of the "expectant treatment" so universally accepted and adopted by the profession, and which, in a few seemingly well authenticated instances, has led to recovery.

The appeal was uttered in behalf of the vast majority on the side of fatality attending these cases, and was based upon the deductions to be drawn from the recoveries following operations for diseases affecting the viscera of the abdomen and pelvis, during which the most terrible injuries have been inflicted upon the contents of these cavities—the peritonæum exposed for hours, as well as brought in contact with all kinds of foreign and usually irritating substances.

It is scarcely necessary for me to affirm in your presence the fact that, with few exceptions, the older writers and surgeons

advocate the "expectant treatment" in the management of these injuries, while the younger writers and surgeons favor operations, pinning their faith upon the wonderfully favorable results attending the practice of Listerism, the purest of antiseptic surgical methods.

During the past few months I have instituted and carried out, with the valuable assistance of Mr. J. McDill and Drs. Anthony, Freer and Bolles, a series of experiments for the purpose of ascertaining the results to be obtained by immediate operations after these wounds, with the hope that the relation of the attending circumstances and events would be interesting as well as useful, by adding to the data now in our possession other data, from which may be determined more intelligently the course of action to be adopted when these cases come under our charge for treatment.

No attempt will be made to review the great question of penetrating gun-shot wounds of the abdomen, which would lead me beyond the scope of the paper. Nothing but a fair recital of the history of the experiments, with some application of the conclusions to be drawn therefrom, will be undertaken. With this intent in view, there will be presented to you the accompanying phenomena, the manner of treatment and results of thirty-seven intentional gun-shot wounds of the abdomen, confining my attention entirely to my own observations, and exhibiting to you such specimens as I have been able to preserve, taken from the animals; both of those which died, and of those which were sacrificed, after recovery, to obtain the specimen. Experiments of like nature have been made upon animals by very many surgeons, previous to the application of their convictions of the necessity of certain procedures to relieve disease or the effects of injury on the human body.

No preparation of the animals selected for experiment was

made, either as to choice of physical condition or surrounding circumstances, except that they were anæsthetized previous to being hurt. The wounds were produced by the ordinary Smith and Wesson revolver of 22, 32, 38 and 44 caliber, and by the 22 caliber rifle. The shots were given at short range, so the damage done by the bullet fairly represents the injury met with, either in military or civil practice, as the results of shots from the firearms now in use.

At first, no attempt was made to give a definite direction to the course of the bullet, other than that it should perforate the abdominal cavity. The results soon confirmed the fact so well known, that the larger number of patients suffering from such wounds never come into the hands of the surgeon, their injuries proving rapidly fatal.

This ending, we can readily understand, must be a common one, when we bear in mind the construction and nature of the viscera contained in the cavity, especially their great vascularity, having vessels of immense size supplying them with, and carrying away from them, the blood necessary for their nutrition and the performance of their special functions; not to mention the main systemic artery and vein coursing through the cavity in a position rendering them readily liable to perforation, death following speedily.

It was also ascertained that a severe perforating and lacerated bullet wound of the viscera, such as of the kidneys, of the spleen, and of the pancreas, could not apparently be treated successfully in any other way than by an absolute removal of the injured organ; and notwithstanding the reported successful removal of almost every important organ of the abdomen by one surgeon or another, the conclusion was reached that some of these organs must be left *in situ*, in order that the functions of life may be carried on.



Hence we were compelled to exert such control over the course of the missile as to have it produce a wound of the nature of those likely to come, and actually coming, under the care of the surgeon; so that the injuries became those confined to perforations and injury of the intestinal tube, with occasionally the injury of some of the larger special organs.

It will not be amiss to recall to your minds, very briefly, some of the triumphs of abdominal surgery, and more especially to impress the fact that shot wounds of the cavity and contents present many questions of prime importance which are not met with in, and do not complicate, ordinary operations for disease or injury with any free, external wound.

The removal of the spleen for acute wounds nearly always results in recovery; so also one kidney has been removed successfully, either for disease or injury, often enough to place the operation of nephrectomy among the list of justifiable undertakings.

Again, wounds of the intestinal tube of all degrees of severity, up to complete division by the resection of portions of the entire calibre thereof, have been successfully treated by surgeons, as is proved by the experimental researches of Dr. Traverse, the eminent Prof. S. D. Gross, Dr. Bell, and others, and confirmed by the experience of many surgeons during operations upon the human being for diseases of these cavities. Still, in each of the examples mentioned, the circumstances were entirely different from what is found present in perforating gun-shot wounds of the abdomen. In the former, the peritoneal cavity was clear of blood and other extraneous substances; the prevention of their entrance entirely under the control of the operator. In the latter, blood in large amounts was always found present; and the peritonæum was smeared with the contents of the intestinal tube, necessitating prolonged

efforts to secure a cavity clear of all hurtful substances. Of necessity, the latter cases would be least likely to escape the probabilities and dangers of subsequent inflammation of the serous membrane.

Primary resection of portions of the intestinal tube, or entire removal of separate organs, are operations comparatively easy of performance, and are not necessarily attended with any damage to or exposure of any other portions of the abdominal cavity, outside of the immediate proximity of the site of the operation.

Extravasation and hæmorrhage should be entirely prevented and controlled; and the peritoneal sac can be maintained perfectly clean during the time of, and after, all the procedures required by the operation.

After gun-shot wounds, besides the resection or removal of any special organ required, there is great shock, and prolonged manipulation is necessary to obtain a proper cleanliness.

The recital in detail of each experiment would be tiresome and occupy too much time, so that your attention will be called only to the more important facts and circumstances determined by them.

There will be published with the paper a somewhat extended account of each experiment, from which individual inferences may be drawn. In addition, a short *resume* of the entire work will be given further along.

First comes the question of hæmorrhage and damage to blood-vessels, as this is primarily the most common and certain cause of death, and demands the surgeon's first attention. In its excessive amount, occurring rapidly and suddenly, is to be found the explanation of the cases which are immediately fatal. This result will surely happen when the largest arterial trunks are severed by the bullet; further, its copiousness and persist-

ency of flow, even when none but very small blood-vessels are divided, involve a matter of serious concern, if not a fatal issue, either from the amount of blood lost, or in predisposing to septic processes from blood decomposition.

There is a remarkable persistency in the flow of blood following the severance of vessels in the abdominal cavity, perhaps dependent upon the laxity of the tissues through which these vessels course, the absence of pressure from surrounding soft parts, and the lack of the peculiar influence of the atmosphere, either from its weight or clot-producing power.

When the abdomen is opened immediately after the transit of a bullet, its cavity is found to contain a large amount of blood, the quantity, of course, being in proportion to the size of the vessels wounded, but always a disproportionately large amount, no matter what their calibre; further, the flow is still going on from vessels of all sizes. There seems to be slight disposition to the formation of an obstructive clot in the mouths of the smaller ones, and slow retraction or contraction of the walls of the larger.

Bleeding stops only when the heart ceases to beat in a faint from excessive loss, or when the amount of blood is so large that by its bulk, and weight, and distension of the abdominal walls, it makes pressure sufficient to occlude the open vessels.

The conditions are very quickly altered after air is admitted through the abdominal section. Clots rapidly seal up the smallest vessels; the smaller arteries spurt less forcibly and soon cease beating; the larger ones contract and retract, just as occurs in the wounds of soft parts in other regions of the body. This is in accordance with, and corroborative of, the experience in hæmorrhages occurring in abdominal surgery in the human being. Few of us have failed to see cases like this: a patient dies suddenly, with all the symptoms of

acute prostrating hæmorrhage; post-mortem examination shows the abdominal cavity filled with blood; the blood is carefully cleared away in the search for the source whence it came; and when this is found, it is a matter of astonishment that such a vast amount of blood could come from so small a vessel. Perhaps it is a small vein of the ovarian venous plexus, or a minute vessel in the thin-walled sac of an extra-uterine fœtation, or the partially closed vessels in the shrunken stump of a recently removed ovarian or other tumor, or some recently divided adhesions, all of them vessels which, in any other part of the body, would be no item of concern to the surgeon, or need any of his special care to prevent bleeding from them.

The lesson taught by these facts is of imperative importance in all operations upon these cavities; and even if mastered, loses nothing by reiteration. Excessive hæmorrhage being certainly the principal cause of speedy death in severe gunshot wounds in this region of the body, where evidences of its presence are plainly exhibited, there can be no hope whatever of saving the lives of any of the wounded except by immediate abdominal section. This alone, by admitting air quickly, staunches the fast flowing current, and gives time for the application of the ordinary rules of surgery for the prevention of hæmorrhage.

In order to be safe from subsequent trouble, every divided blood-vessel must receive the surgeon's attention, occluding clots must be thoroughly sponged away, and in their stead must be placed the ligature or the sear of the actual cautery. If left without this restraint, and the abdominal opening be closed, the same conditions are restored as existed previous to the section; and as reaction comes on, bleeding will surely recur, and in large amount, leading to death from this cause alone, or furnishing a frequent source of septicæmia.



This fact again is corroborative of the experience of ovariologists, the most successful being those who take the greatest pains to staunch all bleeding before closing the abdomen.

Following a resection of three or four inches of bowel and a ligation of two large subdivisions of the mesenteric artery wounded by the bullet, there occurred a mortification of several inches of the entire intestine above the site of resection. The mortified part corresponded with the distribution of the arteries wounded and ligated. This assuredly was an important fact to know, if at all likely to occur as the result of wounds of these arterial branches; even its accidental occurrence is a circumstance to be remembered. Its occurrence would surely add largely to the gravity of the cases in which it happened, probably necessitating a resection of a portion of the intestine corresponding to the area of distribution of the wounded vessel. The great freedom of anastomosis between the mesenteric arteries rather argues against their wounds being followed by any such hazardous result; still, the case recorded above required explanation. Two experiments were performed in order to determine whether destruction of the arteries alone was sufficient to lead to such mortification.

Both demonstrated that a closure of two or three of the largest subdivisions of the main mesenteric vessel was not in itself sufficient to produce death of the portion of intestine supplied by them. The experiments were as follows: an animal was anæsthetized, and the abdomen opened. A sufficient length of bowel was drawn through the opening to allow of the ligation of two large sets of vessels adjoining each, the ligatures including vein and artery. The parts were returned to the abdomen and the latter closed. At the end of thirty-six hours the wound was reopened. No very noticeable change was found in the intestine; pulsation had returned in the ligated

vessels beyond the ligature. The external wound was again closed. The animal recovered in a few days so as to be as lively as ever.

A second animal was etherized, and a ventral section made. Three large vessels were ligated (veins and arteries), before their division into any branches. These three vessels lay parallel with each other. A ligature was also thrown around the anastomosing branch near the intestine which connected with a fourth larger vessel. There followed immediately very marked whitening of the bowel. The parts were returned and the wounds closed. The animal recovered promptly from the effects of the ether and the immediate effects of the operation.

It remained quite well for six days, when it grew ill. The wounds were reopened. Pulsation had returned beyond the ligature. There was no sloughing or mortification of the intestine. It was congested slightly and seemed paralyzed, and was of wider caliber opposite the distribution of the ligated vessels; this was the only change. There was a great deal of very offensive matter in the peritoneal sac, and notwithstanding the high grade of inflammation, there was no adhesion of intestinal folds except at one point. Here there was found a perforation of the intestine. Out of the opening there protruded a piece of wood which, upon being pulled out from the cavity of the intestine, was found to be four inches long, and connected with a large mass of twine. This had evidently been swallowed by the animal, and had gotten along safely enough until it reached the inactive portion of the tube corresponding to the seat of operation, where it was forced through the tube by the strong contractions behind it. Unfortunately, the animal was killed by the ether during the examination. Aside from this accident, the animal had a good chance of recovery.

The complication of a complete resection of the bowel, with

a ligation of two or more vessels, is the only explanation to be given of the case where mortification occurred. The experiments prove that such result does not follow simple closure of the vessels by ligation.

The second item to be considered refers to the course of the bullet and the character of the damage done by it. Nothing can possibly be more uncertain and erratic than the track of the missile through the body. A contracting muscular fiber, an edge of fascia, the elasticity of the skin, a surface of bone, or a distended knuckle of intestine, each and all of these at times present obstructions sufficient to divert it from the direct line of its flight. It is certainly astonishing what very extensive and severe lacerations of the intestines are produced by so small a bullet as one of calibre No. 22, Fig. 1. c.; the entire circumference of the bowel at some points being mangled beyond recognition; again, it is equally surprising how minute are the perforations made by the large No. 44, Fig. 2. As a rule, the larger the calibre of the bullet the larger the wound.

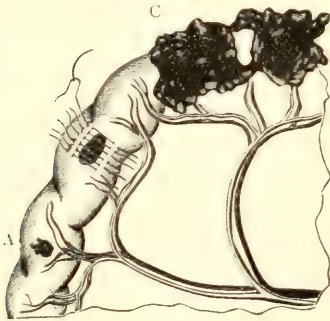


Figure 1.

An estimate of the direction of transit, based upon the points of entrance and exit, is purely conjectural, and furnishes no standard whatever by which we may judge of any supposed injury to any organs known to lie in such course. In one experiment, the bullet made

four openings through the abdominal walls, and did no damage other than contusion of two knuckles of the small intestine and gouging the serous membrane.

The animal had a remarkably deep furrow along the course of the "linea alba." The bullet entered the right side of the ab-

domen obliquely, two inches from the mid-line, perforated its walls, and coursing to the left, furrowed the peritonæum in its passage; was evidently deflected outwards, immediately before reaching the linea alba, by a knuckle of intestine, which it contused slightly.

Here it made its first exit through the walls, passed to the left side of the mid-line, again perforated the abdominal walls, and, furrowing the peritonæum upon the left side, finally made its second exit through the abdominal walls three inches to the left of the linea alba. Near its place of final exit, a second knuckle of intestine was found badly contused. The contusion was so severe and extensive that it was thought best to resect a length of one inch. The animal recovered.

In a second instance, the bullet entered the cavity about two inches to the right of the linea alba, on a line with the umbilicus, with a direction upwards and to the left side. It made its exit nine inches to the left of the mid-line, and just at the lower edges of the last rib. On opening the abdomen the stomach was found greatly distended, entirely concealing the other viscera from view, and presented two large perforations in its walls about two inches apart, from which some blood, mucus, and food were found running into the peritoneal sac. The wound to the right, in the stomach walls, was the smaller, and situated directly opposite the entrance perforation in the abdominal wall, having the same direction. The wound to the left in the stomach walls (two inches to the left) was the larger, very ragged, and had evidently been made by the bullet deflected forward at its first entrance into the stomach. After leaving the stomach the bullet impinged upon the inside of the abdominal walls just to the left of the mid-line, and then, instead of perforating them at that point, was again deflected upwards and to the left, merely furrowing the peritonæum along the remainder of its course to the point of exit mentioned. The



wounds of the stomach were inverted, as it were, into the cavity of that organ, by bringing its peritoneal surfaces surrounding the wounds in contact with each other by means of the continued catgut suture. The abdomen was carefully cleansed of blood, etc., and the wounds in the walls closed in the ordinary way. The animal speedily recovered from the injury, without any uncomfortable symptoms. During the recovery from the effects of the ether, the animal vomited considerable quantities of blood, giving an additional evidence of the perforation of the stomach.

There were two cases in which the bullets perforated the abdominal walls, and in their transit did no injuries to the viscera, in which the points of entrance and exit were five and six inches apart. In each instance the only damage done was a furrowing and laceration of the peritonæum along their entire courses, the blood from the track of injury falling into the abdominal cavity. In one experiment, the bullet failed to penetrate the abdominal walls and was subsequently dissected from between the muscles. On opening the cavity, quite a rent was found in the spleen opposite to the seat of external bullet wound, from which blood was freely flowing. There was neither abrasion nor perforation of the peritonæum. This case may suggest the probable cause of death in some fatal cases from non-perforating wounds. The laceration was evidently caused by concussion alone.

Other instances might be cited to illustrate the exceedingly great uncertainty as to the course taken by the bullet, and as to the organs probably impaired. They would also confirm the possibility of perforations of the walls without accompanying injury to the contents of the abdomen. Still, no instance was shown of failure to produce a wound thereof when the bullet's course lay among the intestines. Their safety followed deviation by glancing.

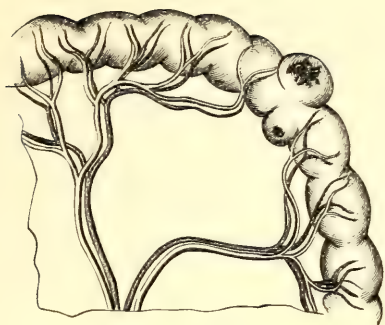


Figure 2.

The wounds of the intestines may be many in number and situated very near to each other (Fig. 3) so that one resection including all the openings will constitute the only operation that furnishes relief.

Again, the openings may be few in number and widely removed from each other; and if each wound is large, and the damage to the tube extensive, such as is usually produced by a 32, 38 or 44 calibre bullet, three or four resections are necessary. The latter are the most difficult cases to manage and most fatal in their results. The position of the points of entrance and exit of the bullet in the intestines is subject to immense variety, even in simple cases. It may involve only the top of a knuckle of intestine, merely opening the cavity thereof. The points may be so near each other that only a half inch or less of intestinal wall separates them from each other. (Fig. 1, a.) The bullet may merely cut off the mesenteric junction opening into the cavity more or less freely. The intestine is often perforated transversely near the

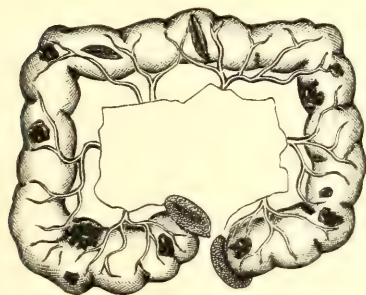


Figure 3.

middle, or longitudinally; in the latter case the bullet, entering at one point, courses along in the cavity of the tube for some inches, and then makes its exit.

All of these varieties depend upon the situation of the intestinal folds with reference to each other at the time of the transit of the bullet. One case

showed 10 complete perforations in 18 inches of length of the ileum, Fig. 3.

Extravasation of the contents of the tube was present in every instance where there existed the slightest degree of perforation. These contents were forced out into the peritoneal cavity, or on to the surface of the intestines, if the wound was large, by the bullet itself, and the normal tonic contractions of the bowels; and, if small, perhaps by the latter alone. This facility of extravasation agrees with my experience in wounds of the intestine in the human being. I have personal knowledge of two instances in which the medium-sized aspirator needle was employed to relieve tympanitic distension of the tube with success so far as getting rid of the gas was concerned, and giving great temporary comfort to the patient. Death ensued from the disease. Post-mortem examination in each case demonstrated the presence of faecal extravasation at the seat of the needle puncture. It would not be an arduous task to collate instances of this accident in the practice of others, where this plan has been adopted. It is difficult to understand how any other result could follow a perforation, if there be contents at the seat of the puncture, when we remember how strong and constant is the action of the circular muscular fiber. It is stated that the protrusion or eversion of the mucous coat, which ensues very rapidly after complete division of the walls, acts as an immediate stopper of wounds of small size, say one-eighth of an inch in diameter. This may be true in incised wounds, but it was not shown to exist in a single one of the several hundred perforations coming under my inspection as made by the bullet. The latter tears away and lacerates the parts through which it passes, and perhaps paralyzes the muscular fibers in its immediate neighborhood, but whatever the cause, there was

no instance in which the eversion of the mucous membrane was sufficient to prevent extravasation.

Recognizing the very deleterious influence of this material upon the peritoneal membrane, this fact of the great certainty of extravasation adds another point to the argument in favor of abdominal section in these cases, as furnishing the only means by which this source of trouble can be absolutely eliminated.

As part of the extravasated material from the wounds of the intestine, it was an exceedingly common thing to find intestinal worms of all kinds, and in large numbers protruding from the rents or free in the serous cavity.

In the treatment adopted during these experimentations, it was found necessary to make an extensive external incision, freely exposing the abdominal cavity, in order that all the viscera might be thoroughly and carefully examined, and every wound brought within reach. In a majority of instances the median line gave space enough, in two the bleeding vessels could not be reached without a lateral prolongation toward the flanks.

There was no reason to suppose that the extent of the incision added very much, if at all, to the gravity of the operation. After opening the abdomen, the intestines were all turned out, critically examined for perforation or contusion, the situation of these fixed, and the hæmorrhage therefrom controlled by means of the snap forceps, after which wounds of special organs were sought for. If the substance of the spleen or the kidney was found perforated, the organ was immediately removed after ligating its blood-vessels, the stump being returned to the abdomen. If slight lacerations only at some point on the surface had been produced, these were closed by bringing peritoneal surfaces of the organ over the wound by means of the continued suture.



The peritoneal sac was then carefully and thoroughly cleared of blood and other extraneous substances by repeated sponging or irrigation. The intestines, which during this process had been protected by being enveloped in towels wrung out of warm water, were now cleanly sponged, while all unwounded portions were returned to the abdomen.

It seems to be of little consequence whether or not the intestines be returned to the cavity in any definite order — in fact, it is doubtful whether they are ever returned precisely to the same positions they originally occupied before being disarranged during the operation. Still, some care must be used in order to avoid the accident which happened in one experiment. After the divided ends of the intestine had been united, it was found that during the manipulation one of the ends had in some way been passed through an opening in the divided mesentery, so as to produce a figure of eight convolution in the tube. It was left in this shape. The animal recovered, and I have the specimen with me to demonstrate the perfectness and security of the union in the intestine at the place of reunion. The animal was sacrificed to secure the specimen six weeks after the operation. The abdominal cavity was quite free from evidences of inflammation, except where the misplaced folds lay in contact with each other. At this point slight peritoneal adhesion had formed between them.

Where several wounds occurred rather close together, severe enough to destroy a considerable portion of the integrity of the bowel, one resection was made to include all of them, even when the length of intestine removed measured ten inches or more. Where the points of injury were widely separated from each other and extensive damage done at each point, several resections of a length of the tube just sufficient to include the injured portions were made.

In the former case, in which several inches of the tube were

taken away, the mesentery was ligated as close as practicable to the intestine (Fig. 7), in sections corresponding to the number of blood-vessels going through it to the resected portions. The mesentery was then divided close to the intestinal wall, and a "V" shaped portion of it removed. After this, the tube itself was divided, and the wounded portion removed. One artery, always needing ligation, was found in the divided ends at the point of junction of the mesentery with the intestine. Before the final division of the intestine, its contents were pushed back out of the way, compression exercised upon its walls by a pair of forceps or a temporary ligature, in order to prevent extravasation of its contents through the divided ends. The mark of constriction made by the forceps or ligature, used to close the lumen of the bowel, was to be plainly seen several days after the operation. The safest compression can be made by an assistant's fingers. Results soon demonstrated the paramount necessity of carefully selecting the place for final division of the intestine, in order to avoid sloughing of the edges approximated together, the results being best in those cases where the division was made close to the point at which any given mesenteric artery approached nearest to the intestine, as compared with those where the cut was made in the intervals between any two branches of these vessels, and this was seemingly dependent on the better supply of blood belonging to the former cases. Immediately after division of the intestine, there followed an instantaneous, regular and considerable contraction of the calibre of the tube (Fig. 4, a), close up to the divided edge, caused by the action of the circular muscular fiber. The diameter was often diminished more than half by this contraction. This persisted for a time, but was soon followed by an eversion of the mucous membrane, which rolled out and over the constricted portion in a remarkable manner. (See Fig. 4, a, b and c.)

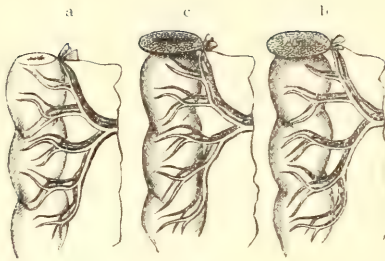


Figure 4

This protrusion of the mucous membrane forms a serious obstacle to easy and close approximation of the ends of the bowel in the efforts to bring them together by sutures; and, when turned into the bowel during such procedure, diminishes its calibre considerably, although it was not demonstrated that the obstruction was ever sufficient to prevent the passage of the intestinal contents. Several efforts were made to get rid of it, and overcome the seeming delay caused by its presence, but all these were finally abandoned.

It was pared away with the scissors; it was dissected up from the other coats for a quarter inch from the edges, but the conclusion was finally reached that instead of being a harm, its presence was useful in giving support, protection, and perhaps vascularity to the freshly sutured edges; at least, in all instances where it was removed, the stitches were found torn out and union defeated; in no instance where it was left entire did there fail to be union in some part, and no sutures gave way when properly applied.

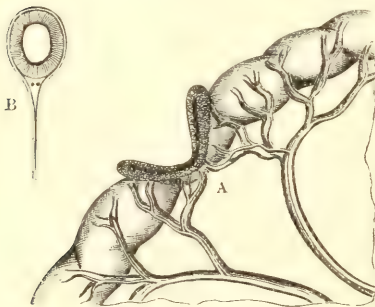


Figure 5.

In all instances where a perforation was severe enough to require a resection of the wounded part, it was found advantageous to leave, if possible, a strip of the bowel near the mesenteric junction (Fig. 5, A), taking out the wounded portion by means of a "V"-shaped incision. The part left acted as a support to the wound,

avoided division of the blood-vessels at this point, opposed the action of the longitudinal fibers, and in no instance in which this plan was adopted was there any appearance of separation of the wound or any displacement of stitches. In perforations through the stomach, the wound did well after drawing the peritoneal surfaces some distance from the edges thereof, over it by means of the continued suture, thus converting it into a linear wound (Fig. 6 B). The same plan was adopted with success in abrasion and small perforations in the small intestines. (Fig. 6 A.)

This way of treating the bullet openings in the bowel is susceptible of much wider application than would appear possible at the first glance. I am quite well satisfied that it will safely take the place of excision in not a few cases of quite severe injury. The torn

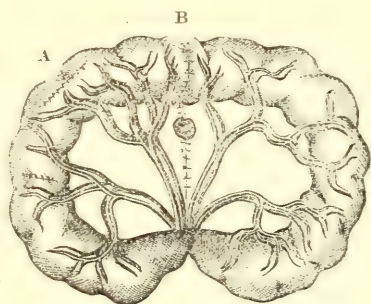


Figure 6.

edges of the wound can be turned in, and peritoneal surfaces fastened together, even in large wounds, with perfect confidence in the result of safe and secure adhesion following.

It seems probable that by far the greater number of successful cases will follow a single resection, even if that include a number of perforations, and involves eight or ten inches of bowel, in comparison with those cases where several excisions are made of wounded portions widely separated.

Perforations passing through the mesenteric surface of the intestine were found the most difficult to treat, and even if slight seemed always to require a complete excision. A partial excision of this surface of the bowel resulted in an acute-angled elbow which never did well.



The point of attachment of the mesentery with the bowel will usually be found the most troublesome to manage, in applying the sutures in restoring a complete division. (Fig. 5, B.) It is quite difficult to so place the sutures as to secure a perfect reinversion of the mucous membrane, to bring serous surfaces fairly in contact with each other, and to get a sound junction. The difficulty arises apparently from the manner in which the folds of peritonæum separate from each other before passing on to invest the bowel, leaving a little triangular interval filled with loose connective tissues, fat and blood-vessels. Now, if the suture fails to include the muscular coats of the intestine as well as the peritonæum at this point, the junction will surely give way and extravasation result. To make this point secure, the greatest care must be taken in placing at least three sutures (Fig. 5, B), this number being usually quite enough to include the troublesome area, and these should always be the first sutures applied. In placing the remaining sutures to complete the junction after placing the three sutures mentioned, at the mesenteric surface, it assists materially in the ease of application, saves time, and especially avoids trouble from the everted mucous membrane, to apply one at the most convex surface, and then one half way down, on each lateral surface. After this is done, the remainder can be introduced easily and rapidly. If introduced in a regular series, one after the other, all the way around, it is a very slow process; the mucous membrane is always in the way, the needle openings in the intestines are apt to be uneven, and it is altogether the poorest plan of proceeding. The advantages mentioned as gained by taking the course suggested, are certainly all of them items of importance, and have some bearing on the result. At best, these procedures will be found very prolonged and tedious. The material used by me for sutures was silk

and catgut—the latter for the continued, the former for the interrupted ligatures. No. 1 catgut; No. 2 silk. The needles were the full curved round needle, or ordinary straight sewing needle; the latter is the best. The sutures were introduced about the third of an inch, never less, from the divided edges, made to include the peritoneal and muscular coats, and brought out just free of the edge on one side, and were

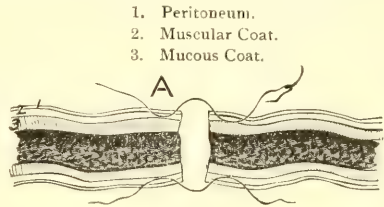


Figure 11.

then reintroduced close to the edge, and made to include about the same amount and kind of tissue on the other side, being *very sure not* to allow the needle to pass into the intestinal cavity. (Fig. 11.) Mr. Howse,\* of London, proved conclusively in his cases of gastrotomy, that the fact of entrance of the needle into the cavity of the tube, carrying the thread with it, made the difference between success and failure, cases dying from peritonitis and extravasation when the entry occurred, and recovery following when the thread included only the peritonæum and muscular coats.

Again, the everted tissue should be turned in before introducing the needle, so that it will pass through the rim of constriction. If entered too far away from the divided edge, too much tissue is turned into the intestine. When the mucous membrane was turned in, and the suture tightened, two broad surfaces of peritonæum were brought in contact. This you will recognize as Lembert's suture (Fig. 6, B), with one change. Lembert directs that only one and one-half line in width of tissue should be taken up by the suture. This amount of tis-

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\* Mr. Howse was the first surgeon to use the double row of sutures for the junction of serous surfaces together. Czerney's suture is an application of it to intestinal wounds. Its use is altogether too tedious, and gives no better result than the single suture including sufficient tissue.

sue will do very well in the closure of small slits, for which it was intended, and to which it was applied; but complete resection needs a much firmer hold to withstand the strain of peristaltic movements. *The fact is, that it makes no difference whatever what kind of suture is used, so that the principle of positively securing the application of two broad surfaces of peritonæum in contact with each other is certainly carried out.* Jobert's, Gely's, and Czerney's double row of sutures were all

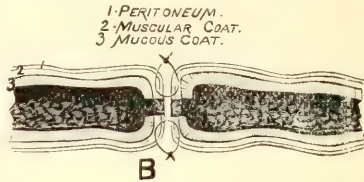


Figure 11.

given a fair trial, but none of them resulted as well as this modified Lembert stitch. (Fig. 11, B.) It never failed to be followed by good union when properly applied, with peritoneal surfaces brought together around the entire circumference of the intestine.

The greatest number of mishaps followed drawing the sutures too tightly, which, if done, leads to death of the applied edges, and, of course, to failure. They must be drawn only sufficiently close to bring the surfaces fairly in contact, the subsequent swelling from obstructed circulation will hold the surfaces firmly together until glued to each other by the rapidly forming adhesive material.

The interval left by the incurving of the edges of the bowel, immediately after the completion of the operation, was found entirely obliterated, and the sutures covered up by effused lymph at the end of twenty-four hours. In one or two instances, where very small openings had been made in the bowel, they were occluded by passing a suture around the perforation, a short distance from its margin, pushing the wound into the cavity of the intestine, and then by tightening the suture the peritonæum was drawn together over it; a very satisfactory

plan of procedure where circumstances will permit its application.

The question of the proper disposition to be made of the divided mesentery, after removal of some length of intestine, is an important one to decide. No plan adopted proved entirely satisfactory.



Figure 7.

Previous to separation it was ligated in sections (see Fig. 7); the part beyond the ligature is apt to mortify and thus prove a focus for fatal inflammation. The tissue of the mesenteric membrane is not very vascular, and the vitality of the distal portion of the stump is seemingly best provided for by causing it to adhere to surrounding vascular parts.

In some cases the stumps were left free in the abdominal cavity; these all did badly, each showing mortification. In others the different sections were all included in one suture and then stitched to the bowel at the seat of operation, making as nearly as possible a continuous surface of mesentery.

These did much better, there being few instances of sloughing. When sloughing occurred, it seemed to be dependent upon and follow a too tightly fastened ligature. This method above mentioned of treating the divided mesentery is useful in another way: it gives support to the bowel at the point of resection, maintains the intestine in proper position by preventing bending, and also leaves fewer raw surfaces free in the serous sac. This last, a condition acknowledged to be the frequent source of serious trouble from faulty adhesions to surrounding organs, and from furnishing points from which septic absorption takes place.

A plan of dividing and treating the intestine and mesentery



has been suggested\* to me as a possible improvement on those already noticed. It is really an application of the plan

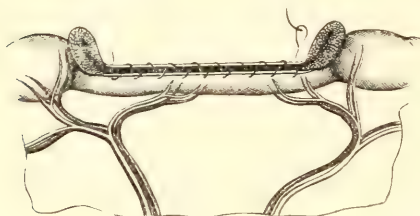


Figure 8.

(Fig. 8), tear away the mucous lining of the retained strip of bowel (Fig. 9), and draw the peritoneal surfaces thereof together by the continued stitch. (Fig.

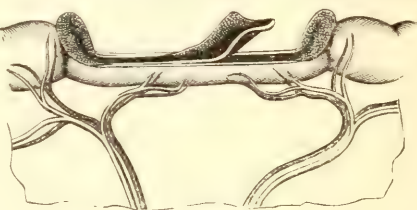


Figure 9.

8). This would avoid division of the blood-vessels going to the bowel, do away with the necessity of using ligatures, and leave

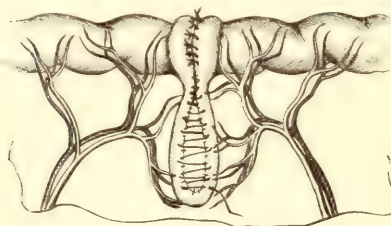


Figure 10.

no raw surfaces free in the abdominal cavity. The opening formed by the folding together where the bowel-ends are united, should be closed by the continued suture. (Fig. 10).

This method was adopted in one experiment with an excellent result.

Bleeding from slight lacerations of the spleen, kidney, or liver can be controlled by actual cautery lightly applied, perhaps the very best method to adopt. If the wound is a complete perforation of the body of the organ, the hæmorrhage is very great, rendering extirpation of the entire organ apparently the only sure way of surmounting the difficulty.

\* Dr. John Bartlett, Chicago.

Quite frequently the entire mass of the greater omentum seemed to require removal. The bullet in the transit not only perforated it here and there, but passed along between its folds as well, leaving injured tissue and blood-clots of considerable size in its track. These clots disseminated themselves in the meshes in such a way as to entirely prevent their removal without tearing the tissue to shreds. When this condition was present in any degree the mass was amputated, after ligation, in sections. In a few instances these stumps gave rise to trouble, either from recurring hæmorrhage or mortification of the distal end.

In the after treatment it was often necessary to administer morphia to secure quiet. Very careful attention must be paid to the amount and kind of food given for some time after apparent recovery. One experiment resulted in failure after the lapse of three weeks from date of operation. The animal was lively, running about as freely as ever, all the functions normal, and the external wounds all healed, when it suddenly sickened and died, having tetanus accompanying rupture of the intestine, several inches above the seat of resection. Post-mortem examination showed masses of food and grit and greasy cloth, occluding the intestine, and distending it so enormously that rupture was produced; the tube at the seat of the operation was patulous and nearly of usual size. This animal was lost solely through neglect in the matter of feeding. Milk alone was given in all other cases for some weeks after operation. Certainly this is a matter of great importance, and suggestive of the proper care to be given after all such operations. Extreme emaciation occurs during the first week following the operation, and, if there is shown any likelihood of recovery, there follows a voracious appetite, which should be very sparingly gratified.

The circumstances under which these experiments were done, were such that it was absolutely impossible to carry out full antiseptic appliances. The external incision was treated with iodoform and oakum or absorbent cotton, and with two exceptions healed by first intention.

The bullet wounds through the abdominal walls were not probed nor disturbed in any way. Occasionally, when large and much contused, iodoform was poured on them. In only two instances did they suppurate or give rise to any trouble whatever, crusting over and healing rapidly. This result clearly enforces the rule of not disturbing the track of a bullet through the soft parts unless the most urgent reasons call for interference. The damage of a serious nature is not in the abdominal walls, but in the cavity; the nature of it can be better ascertained and the most satisfactory treatment adopted, after section through the linea alba, rather than by enlargement of the wound of exit or entrance, if any surgical interference be instituted.

In gun-shot wounds of any part of the body, it is not the injured muscular tissue or fascia that causes grave concern, but the torn arterial trunk, or severed nerve, or fractured bone made by the missile, and here, too, incisions out of the course of the bullet track often furnish the best exposure of the parts for manipulation.

None of the wounds of entrance were perpendicular to the surface of the abdomen. All were more or less obliquely directed through the component tissues of the walls, so that they were valve-like in character and tended to close spontaneously. None of these cases presented any extravasation of the contents of the intestines through the external wounds, notwithstanding the lacerations of the tube were often very extensive, and considerable quantities of faecal matter were found in the

peritoneal sac. The conclusion naturally follows, that the discharge of such matters, through the external openings, is not of frequent occurrence after the wounds under consideration. The absence thereof is far from being proof of the non-occurrence of perforation of the intestine.

It can scarcely be expected that extravasation through the wounds in the abdomen will often happen as an immediate occurrence. This is most likely to occur, if present at all, several days after the injury, following adhesion of the bowel to surrounding parts, and the accumulation of considerable quantity of matter.

There is no reason to suppose that interference with the adhesions to be met with in operations, done some time after the injury, would be followed by any worse consequences than that which follows their disruption during the performance of operations for ovarian or other tumors. The hazard supposed to attend their severance is certainly exaggerated. With a clean cavity they will do equally well in all cases.

These experiments have not developed any data which will aid in the positive diagnosis of the severity, or extent, or kind of injury done to the viscera, or render such diagnosis less difficult than heretofore, previous to abdominal section.

They go a step in advance of this by supporting the assertion that it is absolutely useless to expect immunity from perforations of the intestines when the bullet has traversed the cavity. It seems, and is infinitely more reasonable to subject a patient to the slight risk of an abdominal section, showing unwounded intestines, than to allow him to pass through the fearfully deadly peril of wounded intestines unrelieved, on the barren supposition that they may have escaped injury.



Some uncertainty as to its necessity is likely to arise, except in those cases showing extravasation of the contents of the bowels, or those where the free loss of blood, as indicated by the usual symptoms accompanying such accident, calls for aid. When doubt exists, and a critical condition of the patient argues severity of lesion, abdominal section surely seems to promise relief that can come in no other way. Exploratory incision of the abdominal walls has been done so often, and with so little hazard, as to entitle it to be classed as a procedure in itself almost destitute of danger. Such a conclusion is certainly supported by the results developed during these trials. The rule was, no trouble whatsoever from this incision.

No deduction can more justly or positively follow, as the result of these experiments, than that an incision *de novo*, through the linea alba, is the best method of procedure in the treatment of the class of wounds under consideration; a plan far preferable to enlarging either of the openings made by the bullet. It at once gives command over the entire cavity; therefore any lesion likely to result in harm is far less liable to be overlooked; it is the least vascular part of the walls; incisions thereof are more easily and perfectly co-adapted than elsewhere, heal readily and soundly, and as a consequence, the oncoming cicatrix is less likely to be followed by ventral herniæ.

Thirty-nine (39) animals were used in these experiments, exclusive of those dying from the effects of the anæsthetic. Two of the thirty-nine were used to demonstrate the effects of closure of the main branches of the mesenteric artery upon the nutrition of the intestines. Of the remaining thirty-seven (37), three cases died immediately after the shot

or from the effects of profuse hæmorrhage; one having a division of the aorta just below the mesenteric artery; the second had a large laceration of the kidney, with a wound of the renal artery; the third, a laceration of both kidney and spleen. One case, No. 4, had tetanus three weeks after operation, and is given a special position, simply owing to the presence of this condition as a complication in the case. The post-mortem examination, as already mentioned, developed other conditions which would have caused death, and which were no doubt the cause of the tetanic convulsions. Twelve of the remaining cases died inside of twenty-four hours, either from severe primary or recurring hæmorrhage, and the effects of the very extensive character of the wounds. Two out of this twelve (12) were cases requiring removal of the pregnant uterus, accompanied with many perforations of the bowel; death in both occurred from secondary hæmorrhage from uterine stumps—the ligature having slipped. Three (3) more had slight lacerations of the spleen and numerous perforations of the intestine. The spleen was removed and several inches of the tube excised in each case. In three (3) others, from twelve to twenty inches of the bowel was excised, and many arterial trunks severed. One of the twelve (12) had rapid mortification of five or six inches of the entire caliber of the bowel, apparently dependent upon the division of two large mesenteric arteries by the bullet, and also the resection of six inches of the intestine. The remaining three (3) of the number dying inside of twenty-four hours, are classified as having died of shock. On all of them the damage done by the missile was of excessive severity. The bullet was of large size (38 or 44 caliber), and the fire-arms possessing great penetrating

and lacerating power. There was not manifested in any case any recognizable evidence of shock aside from that following great loss of blood. The transit of the bullet made no noticeable impression upon the pulse or respiration. In every instance where signs of severe prostration became manifest through change in respiration or weakening of pulse, there was found profuse hæmorrhage to account for such condition. I am inclined to infer that the cases are exceptional indeed, in which purely nervous shock will give rise to symptoms severe enough to mislead one to perform an unnecessary ventral section; rather, when severe constitutional manifestations follow the passage of a bullet through the abdominal cavity, good cause for them will be found, as soon as the cavity is opened, in wounded viscera or blood-vessels, and this course will often be the only possible way of either actually saving life or even prolonging it. None of these twelve cases could possibly have lived longer than twenty-four hours after the injury received. Most of them would have died much sooner without the control of hæmorrhage, alone made possible by the opening.

Two cases of the series were subjected to the expectant treatment. These cases were chosen because their injuries did not seem very severe; the hæmorrhage was not great, and the prostration not extreme. Both died; the first in one day; the other lived five days. Post-mortem examination showed extensive extravasation of the contents of the bowel and septic peritonitis.

In one case an attempt was made to establish an artificial anus. The wounded intestine was resected, and the ends fastened to the edges of the abdominal incision. The animal died of septic peritonitis in three days. This trial was made

early in the experimentation, before any definite plan of procedure had been settled upon. This is the only experiment that has given rise to any regret, for I feel satisfied that, with a fair junction of the bowel and a clean abdomen, the animal would have been saved.

Eighteen of the thirty-seven (37) have thus far been accounted for; of the remaining nineteen (19), ten (10) died and nine (9) recovered.

The ten fatal cases lived from three days to three weeks. Peritonitis from one cause or another seemed to be the precursor of death. In six of them, mortification of the ligated stumps of the divided mesentery, together with mortification of the edges of the recently united bowel, were present. In the one that lived three weeks, death was the result of intestinal obstruction, caused by the adhesion of a fold of the intestine to the stump of mesentery left free in the cavity. An acute flexure was produced at the point, against which the contents of the bowel had accumulated in large quantity. A rupture was found above this mass, through which extravasation had taken place. The inflammation was so intense that everything was matted together, and the specimen so horribly offensive it could not be preserved. There was no separation at the point of operation on the bowel; it was thicker here than elsewhere; but full distension with water was allowed without leaking. All of these cases demonstrate conclusively the necessity of great care in the manner of dealing with the divided mesentery, and in the application of the sutures which bring the separated bowel-ends together. The remaining four furnished evidence of separation of the recently united parts of the intestine at the mesenteric junction. In all of them the thread failed to



include the muscular and fibrous coat of the bowel, holding only the peritonæum. The result was extravasation, and death followed.

It may be a matter of surprise to you that the percentage of successful cases presented is so small—nine out of nineteen of those surviving over 24 hours—so few out of so many. To me, knowing well the extremely adverse circumstances under which these experiments were performed, it is a matter of astonishment to have so many recoveries included in so few cases. It is suggestive to remember that all the recoveries followed the use of the modified Lembert method of bringing the peritoneal surfaces together, while in many of the failures, trials were made of other methods. Full six weeks have gone since the last case followed by recovery was subjected to operation. The first favorable case was treated four months ago. None of the animals present evidence of being other than in their usual health. The longest resection of intestine among the recoveries measured over six (6) inches and included four (4) perforations.

It is scarcely possible to do work of any kind under more disadvantageous surroundings than accompanied the performance of these experiments. The operative work was carried on, and the animals kept in the prosector's room of a medical college during the winter season, in the midst of the odds and ends and bad hygienic conditions of such a place. No better accommodations could be secured. The labor has been purely one of experimental inquiry, and not a striving after recoveries, implying a choice selection of attending circumstances and special preparations to that end; therefore, I judge it proper and fair to claim the results as satisfactory. These results certainly indicate that a better

showing is likely to follow where more satisfactory control can be had over both patients and surroundings than was present during these examinations.

They clearly demonstrate that a hopeful expectation of recovery may be entertained after operation, and suggest the nature of the injuries produced, what accident to avoid, and what treatment to adopt.

My confidence in coming before you with no better record is assured, when I remember that all of you are well aware of the great mortality of these injuries, under all circumstances. It must be large, surely, when Dr. Otis, in the surgical history of the war, says the authenticated cases of recovery can be counted on the fingers of one hand. It cannot be said that operative interference in these cases has as yet an established position. Still, perhaps Dr. J. Marion Sims looked with prophetic eyes upon the future, when he closed the article already referred to with the following words: "I have the deepest conviction that there is no more danger of a man's dying of a gunshot or other wound of the peritoneal cavity, properly treated, than there is of a woman's dying of an ovariectomy properly performed. Ovarian tumors were invariably fatal till McDowel demonstrated the manner of cure, which has now reached such perfection that we cure from 90 to 97 per cent. of all cases. And by the application of the same rules that guide us in ovariectomy to the treatment of shot wounds penetrating the abdominal cavity, there is every certainty of attaining the same success in these that we now boast of in ovariectomy."—*British Medical Journal*, March 4; 1882.

In a rather quaintly-written but richly-laden book on surgery, by Herr. L. Heister, Professor, etc., written in 1739, there occurs this passage:

"When the intestines are wounded but not let out of the

abdomen, and therefore the wounds are out of reach, the surgeon can do nothing but keep a tent in the external wound, according to the rules laid down at chap. V, and after this bleed the patient if his strength will admit of it, advising him to rest, eat abstemiously, and to lie upon his belly; the rest is to be left to Divine Providence and the strength of his constitution. But the question may be asked here whether a surgeon may not very prudently, in this case, enlarge the wound of the abdomen, that he may be able to discover the injured intestine and treat it in a proper manner. Truly I can see no objection to this practice, especially if we consider that upon the neglect of it certain death will follow, and that we are encouraged to make trial of it by the successes of others. Sacherus, in *Programmate Publico*, Lipsiæ, ed. 1720, mentions a surgeon who performed this operation successfully."

A period of 100 years and more has rolled away since Dr. Heister published his belief and reported recovery, to the time when Dr. Sims expresses his convictions—over a century of doubts, timidity, uncertainty, and gloomy misgivings, lightened only occasionally by some bold and resolute assertions. The future asks for action, and it is not unreasonable to assert that careful trials will accomplish successful results.

Avoiding any spirit of dictation, it seems proper to tabulate the following conclusions as an outgrowth of the experiments:

First. Hæmorrhage following shot wounds of the abdomen and the intestines, is very often so severe that it cannot be safely controlled without abdominal section; it is *always* sufficient in amount to endanger life by secondary septic decomposition, which cannot be avoided in any other way than by the same treatment.

Second. Extravasations of the contents of the bowel after shot injuries thereof are as certain as the existence of the wound.

Third. No reliable inference as to the course of a bullet can be made from the position of the wounds of entrance and exit.

Fourth. The wounds of entrance and exit of the bullet *should not be disturbed* in any manner, except to control bleeding or remove foreign bodies when present. They need only to be covered by the general antiseptic dressing applied to the abdomen.

Fifth. Several perforations of the intestines close together require a single resection, including all the openings. Wounds destroying the mesenteric surface of the bowel always require resection.

Sixth. The best means of uniting the wounded intestine after resection is by the use of fine silk thread after Lembert's method. It must include at least one-third of an inch of bowel tissue, passing through only the peritoneal and muscular coats, never including the mucous coat. The everted mucous membrane must be carefully inverted, and needs no other treatment.

Seventh. Wounds of the stomach, small perforations, and abrasions of the intestine, can be safely trusted to the continued catgut suture.

Eighth. Every bleeding point must be ligated or cauterized, and especial care devoted to securing an absolutely clean cavity.

Ninth. The best method of treating the stumps of divided mesentery is to save the mesenteric surface of the bowel as above indicated.

Tenth. *Primary abdominal section* in the mid-line gives the best command over the damage done, and furnishes the most feasible opening through which the proper surgical treatment of such damage can be instituted. Further, its adoption adds but little, if anything, to the peril of the injury.



Eleventh. Is not the moral effect of the assurance to the patient, that he will be placed in a condition most likely to lead to his recovery, a good substitute for the mental depression accompanying the general and popular conviction that these wounds mean certain death?

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## EXPERIMENTS ON GUN-SHOT WOUNDS OF THE ABDOMINAL CAVITY.

[Appended to *Dr. Parkes' Address.*]

### EXPERIMENT NO. 1.

Wednesday, November 14, 1883.—Long, lean and lank setter; about 30 lbs.; in rather poor condition. Etherized with common ether and shot through abdomen with a No. 32 cal. ball, which passed directly through anterior wall to the innominate bones. Upon opening abdomen found ileum perforated about the middle and at the ileo-cæcal valve, and slightly grazed at another point. Extravasation of intestinal contents at each perforation. Some entozoa. The two perforated regions were resected and continuity of ileum re-established by Lembert's intestinal stitch. The grazed portion was closed by continued suture. Intestines washed with a feeble solution of carbolic acid, and returned to abdomen; and the external wound closed by two sets of sutures, one set through muscular walls, including peritoneum, and the other uniting the skin. Drainage tube inserted, and wound dressed antiseptically with gauze, cotton, etc.

Entire operation lasted about one hour, and conducted antiseptically, abdomen being shaved, washed and irrigated with carbolized solution, etc. The animal waked considerably shocked. Gave rectal injection of alcohol and water (1-2 1-2), about 3 drachms, and in half an hour gave 10 drops of lauda-

num. The dog seemed very bright. At 6 p. m. was considerably weakened; respiration very rapid, with much febrile excitement. About three-quarters of a pint of warm milk per stomach-tube, twelve drops of laudanum, and about a quarter-grain of morphia hypodermically. Tied him under register well bedded in a large comforter, and covered him with a coat.

Thursday, November 15.—Dog died between midnight and morning. Post-mortem. Abdomen filled with bloody serum and intestines inflamed and badly smelling; kidneys a bright blue, and rectum filled with hardened fæces. Dog had vomited during the night a quantity of hair and some pieces of cartilage, etc. Died of shock. Wounds of intestine well agglutinated.

#### EXPERIMENT No. 2.

Friday, November 16.—The ball (32) severed the aorta.

#### EXPERIMENT No. 3.

Saturday, November 17.—(Ball 32 cal.) Dog etherized, shaved and shot very near abdominal margin. Upon opening abdomen (incision  $3\frac{1}{2}$  inch), but one loop of gut was found perforated. This was excised, and the continuity of intestine restored by eighteen individual silk stitches, which brought serous surface to serous surface, the greatest difficulty being encountered at the mesenteric attachment to the gut on account of the fat which lay between the two layers of peritonæum and adherent to the gut itself. Extravasation of intestinal contents. Tape worm.

Wound closed with heavy silk and dressed antiseptically. Gave 15 gtt. laudanum at night.

November 18.—Animal seems bright, but disposed to remain quiet, drinks plenty of water and urinates freely. Respiration hurried and febrile action high,

November 19.—Seemed very well, and partook of some milk during morning, but began vomiting in the P. M. a sour, watery and greenish fluid. Gave per rectum about  $\frac{1}{4}$  grain morph. sulph. at night, and left him sleeping comfortably.

November 20.—Seemed quite lively and comfortable, the dressings having been removed the day before, and a large body bandage applied. About 11 A. M. seemed rather tired, and vomited large quantities of the same sour fluid as before; would not eat meat or drink milk, but drank water freely. Gave about  $\frac{3}{8}$  grain morph. sulph. hypodermically, and during the P. M. he seemed extremely sleepy and much disposed to lie down flat, but is nervous and easily alarmed by sudden noises, etc., etc. This condition lasted all day, and suppose it is the effect of the morph.

November 21.—Died during night. Post-mortem showed a separation of the resection, which had evidently first torn out at the mesenteric attachment. Extensive peritonitis, intestines being agglutinated together and abdomen filled with fluid blood and fæces.

#### EXPERIMENT No. 4.

November 23.—(Ball cal. 32.) Very large dog, weight about seventy-five pounds. Upon opening abdomen found a section of intestine for about six inches perforated in several places, the ball apparently having skipped along inside the gut; at another place the free edge was shot off and other portions of ileum grazed three times. The middle section was resected entirely, and closed perfectly; the shot edge was closed by trimming edge or side of the tube of intestine by a "V"-shaped cut towards the mesenteric attachment, and that also was closed fairly well. This was close to the left end of the pancreas. Each opening showed extrusion of contents. Many worms.

The operation lasted two hours, abdominal wound closed by

two sets of sutures, one set through the muscular walls, the other bringing the skin in contact. Wound was covered with cotton, and bandage applied. Gave 20 gtt. deod. tinct. opium and a little water. Seemed to be doing well all P. M., and at night at six o'clock gave about 20 gtt. more of the opium, and left some water where he could get it.

November 24.—Dog still alive and very thirsty, but vomits the water soon after drinking; gave another dose of opium at night.

November 25.—Bandages have not been changed.

November 26.—Changed dressings; dog seems bright. Gave pint of milk; also opium, which he drank readily, but soon vomited. Gave more milk about noon, which he retained. In the afternoon he seemed much weaker. Gave deod. tincture of opium gtt. 20 at night.

Still lives, but is not strong. Lies in any position in which placed, and seems quite prostrated. Opium as before seems to revive him; he refuses milk, but drinks freely of water, which the stomach promptly rejects. In the afternoon, being no better, removed dressings, and although wound was quite healed made an opening for medium-sized drainage-tube, and let out about a quart of bloody serum; re-dressed the wound after injecting a weak carbolized solution of warm water into abdomen through tube. Gave a rectal injection of alcohol and water (1-2 1-2) warm and gtt. 20 of opium. Is getting very poor, but respiration is regular; pulse very weak and rapid.

November 28.—Gave enema of soapy water very weak. Washed out wound and inserted short drainage-tube and fresh bandages. About eleven o'clock had a passage from bowels of a large quantity of black, tarry, and badly smelling fæces, result of injection per rectum. At 2 P. M. was



very weak. Gave enema of whisky and milk, warm, about 2 oz., and made a stew of small bits of beef and milk in whisky, which he ate greedily. Gave milk and whisky per rectum every three hours, also Valentine's extract of meat.

November 29.—Seems much stronger; had a semi-liquid passage from bowels. Gave enema every four hours of Valentine's extract, milk and whisky; and also fed pieces of raw meat in milk.

November 30.—Steady improvement; another passage which evidently came from above seat of operation. Fed him on raw steak, and gave whisky per rectum every four hours. Sutures through integument have ulcerated their way out; were removed and dog allowed to lick his wound, as he promptly tears off all bandages.

December 1.—Feeding as before, with steady improvement.

December 2.—Another passage from bowels during night. Gave meat, about one-half pound every three hours, which he eats greedily; marked improvement daily in strength and appearance.

December 3.—Same improvement.

December 4.—Sent dog down stairs in basement.

December 10.—Alive and apparently in perfect health. External wound closed completely.

December 11.—Seems sick; refuses to eat; howls at night.

December 12.—Has marked symptoms of tetanus, and is in a state of rigidity with episthotonos.

December 13.—Died, and post-mortem showed an obstruction of intestine by a large mass of meat or a collection of various substances of a gritty consistency which com-

pletely obstructed and occluded bowels for some distance. The bowel was opened above this, and abdominal cavity filled with intestinal contents, and organs all adhered, as result of peritonitis; resection wound quite strongly united. Dog died from careless feeding and obstruction following adhesion of knuckle of intestine to omental stump.

#### EXPERIMENT NO. 5.

Monday, November 26.—(Ball cal. 32.) Medium-sized, well-conditioned and sturdy dog. Shot passed through a six-inch piece of intestine, making several perforations. Much faecal matter free in abdomen, some opposite each opening. Many tapeworms.

November 27.—Made a resection of but one piece six inches in length, including both wounds. In this instance the larger silk sutures were used. After the continuity of the intestine was restored there was a great deal of bleeding from the interior of the abdomen, the origin of which could not find, but allowing the air to reach into all parts of the abdominal cavity, it ceased after considerable loss of blood. A portion of the omentum being filled with blood, it was ligated and removed. In closing abdominal wound was obliged to tear away a certain amount of fat which was closely adherent to interior wall of abdomen, along the line of the wound, in order to introduce sutures so they would not include the fatty mass. Introduced two drainage-tubes, and applied large pad of cotton. Gave some opium, about gtt. 15. P. M. dog seemed considerably shocked, but was quite thirsty. At night gave more opium.

November 17.—Cotton was soaked with fluid from drain-tubes. Removed dressings, and, upon getting him upon his

feet, a small quantity of fluid escaped. In the evening washed out the abdomen with a warm solution of carbolic acid, about  $\frac{1}{2}$ , and applied dressing of gauze. During the day he vomited considerable milk and water which he had drank, and was evidently very weak. Gave about gtt. 20 of opium at night. Died at 8 A. M. on November 28. Post-mortem showed that sutures had parted at mesenteric edge, and death was from peritonitis. Mortification of edges of resection.

#### EXPERIMENT NO. 6.

December 5.—(Ball cal. 32.) Died of hæmorrhage, after being shot, from wound of renal arteries, the ball perforating one kidney. Several perforations of the small intestines, all of them showing extrusion of contents. One large, round worm free in cavity.

#### EXPERIMENT NO. 7.

December 7.—Died under ether.

#### EXPERIMENT NO. 8.

December 7.—(Ball cal. No. 32). Ball opened one of the mesenteric arteries, and after resecting three pieces of intestine, and closing wound nicely (every perforation showed fæcal matter, worms, etc.); she died in less than nine hours from the shock. Great loss of blood; died of loss.

#### EXPERIMENT NO. 9.

December 10.—(Ball cal. 32.) Gave morphine hypodermically at 9 A. M. Medium-sized female dog. Anæsthetized at 9 A. M., and shot at 9.30, first shot simply going

through abdominal walls: second shot higher up and perforating spleen. Operation began at 10.15. Found abdomen full of blood, fæcal matter, and some worms. Removed spleen and large mass of omentum; ligated and removed one piece; resected about three inches in length; perforated in two places. Much hæmorrhage; operation concluded at twelve. Gave opium and whisky; much shocked. Died.

#### EXPERIMENT NO. 10.

A well-nourished bull-dog (female), about twenty-five pounds in weight. Was anæsthetized about 9.15 A. M., and then shaved over the abdomen. Was shot at 9.45 by a 32-100 calibre revolver just posterior to the umbilicus, the bullet entering on the right side about three inches from the median line, the point of exit being in the corresponding situation on the opposite side. On opening abdomen found animal pregnant. There was one wound through the right cornu of the uterus, rupturing the membranes of one fœtal dog, and allowing the escape of the amniotic fluid into the peritoneal cavity. One of the smaller mesenteric arterial branches was cut, and the small intestine perforated in one place. The abdomen contained considerable blood on opening immediately after the shot, and there was slight extravasation of fæcal matter from the gut at openings. The vagina and uterine ligaments were ligated by single carbonized silk ligatures, and the large gravid uterus removed. The hæmorrhage in the mesentery having been checked, the wound in the intestine was resected, about two inches being removed. The free ends were united with the interrupted silk ligature. The peritoneal cavity was sponged



out and washed with slightly carbolized warm water. The external wound was united with about ten silk ligatures, and dressed with iodoform and gauze, the whole being covered with oakum and bandaged. About half a grain of morphia was administered hypodermically; and at twelve the dog was allowed to come from the influence of ether. She showed marked symptoms of shock, but rallied in the afternoon. She died in the night. Post-mortem revealed hæmorrhage from the uterine stumps, and some peritonitis commencing.

#### EXPERIMENT NO. II.

A full-grown, healthy-appearing dog. Etherized at 9.30 A.M. Abdomen shaved and cleansed. Was shot at 10 A.M., still under the influence of ether, the bullet from a 32 S. & W. revolver passing transversely through the lower part of the abdomen. Was placed on table and kept partially anæsthetized until 10.45. The animal then presented signs of extreme loss of blood, feeble respiration and heart action, cold extremities, pallid gums, etc. Abdomen was opened by large crucial incision and found to be filled with blood. Bleeding was ascertained to come from a divided mesenteric artery, and was readily checked by ligature. Clots were turned out, and two wounds of small intestine found. But slight extravasation of contents of bowel into the cavity, still some matter and worms found at openings. The intestine was resected at the site of each wound, about three inches being removed in each place. The cut ends of each were then united by about twelve interrupted silk sutures, so placed as to bring peritoneal surfaces in apposition. Intestines were then returned to their place, the cavity sponged

out, and the external wound closed tightly with silk sutures. This was finished at twelve o'clock, the dog appearing moribund at its close, and remaining in a condition of collapse for about three hours. Reaction then took place, and he was able to stand and walk about. Second day, took some milk, which was vomited at once. This was repeated at intervals during second and third days. Dressings were changed on third day. No discharge from wound. On fourth day vomiting was increased, and was fæcal in character. Dog too weak to stand. Dressings changed again and wound found to be discharging purulent fluid. Died at 4 P. M. on fourth day. Post-mortem showed sero-purulent exudation in abdominal cavity, intestines glued together by adhesive lymph, wounds uniting well, and occlusion of the bowel in the neighborhood of one of them, from its having been sharply folded upon itself and bound in the position by the inflammatory exudate.

#### EXPERIMENT NO. 12.

December 27, 1883.—The bullet, 32 cal., entered the abdomen on a line corresponding to the junction of the anterior and lateral surfaces of the abdomen, just in front of the hind leg, its point of exit on the other side being on the same line a little above the umbilicus.

On opening the abdomen it was found that the lower part of the jejunum was cut in two places within two inches of each other, and that there was considerable blood in the peritoneal cavity from these cut surfaces, there being no mesenteric vessels cut; also fæces and worms.

Both wounds were included in the parts excised, and the cut ends of the intestines were fastened together by three

sutures, and then stitched to the abdominal parietes, thus forming an artificial anus.

Considerable shock was experienced, and owing to a desire to hasten the operation, the peritoneal cavity was not as carefully sponged as it should have been.

The dressing consisted of iodoform, protective and oakum. Of tinct. opii. deod. gtt. 20 were given by the mouth. The operation lasted two hours. On the following day he took a little nourishment: there was no tenderness, but some pus was squeezed from the point of exit of the bullet, the dog lying on that side.

Next day about one-half ounce of pus was forced from the point of exit of the bullet, the dog lying on that side, and by turning him on to the other side an equal amount was obtained from the point of entrance, but there was no supuration from the wounds themselves.

He took a little nourishment and seemed to be in good condition, respiration being normal and pulse regular. He had a free urination from the bladder, and soft stools were passed from the artificial opening. He died during the night. Post-mortem revealed a large amount of septic material in the peritoneal cavity.

#### EXPERIMENT No. 13.

Saturday, December 29.—(Ball calibre 32.) Medium-sized, middle-aged female dog. Gave with the anæsthetic about 38 grain of morphia hypodermically after shot. Abdomen found full of blood; seat of hæmorrhage found at one of the point of perforation, of which there were two; from these issued fecal matter, gas and worms; a medium-sized mesenteric artery having been shot off. All the intestines were drawn out of abdomen for examination, and it was found necessary to resect two

portions which were a considerable distance apart, both places closing neatly and perfectly. Abdomen washed out and external wound closed by one set of sutures and a large pad of oakum laid over and held in place by roller first, and over all a many-tailed bandage. Gave 25 gtt. laudanum.

December 30.—Dog got loose during night and was running around very briskly; room very cold and disagreeable. (On the afternoon of the day of operation some person had opened the doors and windows and exposed the animal to a strong, cold draft for about two and one-half hours.) In the evening gave hypodermically morphine, when she vomited for first time and seemed very weak.

December 31.—Seemed lively and well all day; gave milk, which she would drink but could not retain. About noon gave an enema of Valentine's extract, and in the evening left a pan of milk.

January 1, 1884.—She seems as well as ever, but the floor of the room was profusely decorated with vomit. The milk was all gone. Gave an equivalent of an ounce of whisky, of alcohol and water per rectum, and left a supply of water, as she seemed very thirsty. Bandages changed for the first time since the operation. There had been but little discharge and the wound was in good condition. Applied a large pad of oakum and a wide roller as before.

January 2.—Seems quite exhausted. Gave alcohol and water (1-2 1-2) per rectum about four or five times a day in quantities of about 1 ounce; has a diarrhœa and vomits.

January 3.—Diarrhœa continues, but no vomiting. Has some appetite, and gave raw meat (steak) chopped fine, every two or three hours; also fresh milk, which she drinks readily.

January 4.—Seems quite well, and hungry; fed regularly and removed all dressings; wound in good condition. Removed



all stitches and did not apply dressing again. Appetite good.

January 5.—Dog is seemingly well; has a voracious appetite. Much wasted in flesh, but appears strong.

January 6, 7, 8.—Fed her upon milk; also meat chopped fine and raw.

January 9.—She seemed well enough to be sent down cellar, where she continues gaining strength and flesh.

January 15.—Is perfectly well. Recovery.

#### EXPERIMENT No. 14.

January 9, 1884.—This dog was allowed some milk a short time previous to the operation, hence his stomach was distended.

The first bullet (32 calibre) grazed the abdomen walls, not entering the peritoneal cavity.

The second entered on a line corresponding to the junction of the anterior and lateral surfaces of the abdomen, a short distance in front of the hind leg, coming out a little nearer the median line, and two inches nearer the front leg.

On opening the abdomen it was found there was some hæmorrhage, mucus and particles of food in its cavity and on surface of stomach, and that the lower part of the stomach was wounded, the point of exit being two inches from the point of entrance, passing through the whole thickness of the stomach. There was no wound of the gut. The peritoneal surfaces were drawn together with cat-gut, by inverting the edges and using the continued suture.

Great care was taken in the *toilet de peritonie*. Immediately after closing the external wound he vomited half a pint of blood, mucus and milk. Time of operation was one hour and a half. Then he was given tincture of opii deod. gtts. xx.

The wound was dressed with iodoform, protective and oakum.

On the tenth was given nothing except a little water. On the eleventh he was given a little milk, which caused some dis-

turbance. On the sixteenth the stitches were removed and no dressing applied, there being but slight discharge from the wound made by the incision and none from the bullet wounds. Recovered.

#### EXPERIMENT NO. 15.

Small dog, female, was anæsthetized and shot at 10:30 A. M. (S. & W. revolver, 32 calibre.) First wound passed through abdominal muscles only. Shot again immediately, bullet this time passing transversely through middle of abdomen. Opening made at once by linear incision. But little blood in cavity. All bleeding stopped upon exposure of intestines to air. Five wounds of small intestine found, all showing extravasation of contents. Two resections of five inches each were made to include all wounds. Cut ends were united by a continued cat-gut suture in each place. Intestines returned and abdominal incision united by silk sutures, after thoroughly washing out cavity by 2 per cent. solution of carbolic acid. The operation was finished at 10:30 A. M. Dog was laid in a warm place, apparently suffering but little from shock. External wound dressed with iodoform, covered by protective carbolized gauze, tow and a bandage. Animal died in about twenty hours. Was not given any food or medicine in that time. Post-mortem showed some small blood-clots about the wounds in the intestine. No serum or other fluids in cavity, and no signs of peritonitis. Death from shock.

#### EXPERIMENT NO. 16.

A dog of uncertain breed, about twenty pounds in weight, was shaved over the abdomen and anæsthetized at 10 A. M. Was shot in the abdomen in front of umbilicus, the bullet entering on the right side and coming out on the same side about two inches nearer the median line, not entering the abdominal cavity or wounding the peritonæum. Was shot

again, the bullet entering on the right side, external and posterior to the first, and coming out on the opposite side, about two inches from median line. The calibre of the revolver was 32-100. Upon opening the abdominal cavity the peritonæum was found to be plowed across between the wounds of entrance and exit, and the spleen to be slightly nicked, the bullet having skirted the abdominal walls. The only hæmorrhage was from the external wounds and the spleen and track of bullet. The spleen was removed, its peritoneal connections being ligated by five silk ligatures. The small intestine was resected, about four inches being removed. The abdominal cavity was washed with warm carbolized water. The external wound was sewed up by about ten sutures. The dog came from under the influence of ether at 11:30 A. M. The wound was dressed externally with iodoform and oakum, and fifteen drops of deodorized tr. of opium administered by the mouth. A curious phenomenon was observed upon cutting out the spleen. The stomach and intestine became distended enormously with gas, extruding from the abdominal cavity and covering a large area of the operating-table. They were with difficulty returned with steady pressure. The dog died in the night from shock and hæmorrhages from splenic stumps.

#### EXPERIMENT NO. 17.

January 23.—(Ball cal. 32.) Good-sized coach dog. Bullet passed through abdominal walls without wounding intestines and just entering the peritoneal cavity, as was found after opening abdomen, the point of entrance and exit being on either side of the middle line and five inches apart. Removed the major portion of the greater omentum and also resected about six inches of the ileum and closed the wound by five sutures, the external wound being but two inches long.

January 24.—Seems inclined to be quiet all day; had de-

fecated during the night and urinated very little; drinks but little water, and does not vomit it. Is by nature a very frisky dog, and do not think his extreme quiet very favorable.

January 25.—Seems quiet; no bloating of abdomen; removed bandages; re-applied dressings. Refused milk all day; also water.

January 26.—Gave small quantity of milk in the afternoon; re-applied the dressings which had been removed the day before; found the bullet wounds much puffed up, and that the stitches had slipped in two places, leaving a hole opening into abdomen large enough to admit little finger. The portion of intestine viewed through opening in external wound looked red and inflamed, but not badly so; little running from the wound. Filled it with iodoform and applied pad of oakum.

January 27.—Gave about one-half pound of meat and a quart of milk; seemed to be ready to get well.

January 28.—Fed meat and milk during day, and he seems to be rapidly getting well.

January 29.—Wound gaping, but discharged him to the cellar. Recovered.

#### EXPERIMENT NO. 18.

January 25, 1884.—This dog, a black and tan bitch, having been shaved the day before, was anæsthetized and shot.

The bullet, 32 calibre, passed directly through the abdomen about its middle, piercing the gravid uterus in two places, and cutting the gut longitudinally. No large vessels were cut. The uterine attachments were ligated *en masse* and the uterus removed. Contents of bowel found at site of wound in intestine.

During the time that an excision of the gut was being made, a profuse hæmorrhage occurred from the uterine stumps, before they could again be ligated by passing a suture through and ligating one-half at a time, the animal was almost exhausted from hæmorrhage.



The excision of the gut was then completed, and the cut ends stitched together with silk. The peritoneal cavity was then thoroughly washed out with slightly carbolyzed warm water, and the external wound closed. The dressing consisted of iodoform, gauze and oakum.

Of tinct. opii. deod., gtts. xx were given. Death occurred within ten hours after the operation, from effects of the hæmorrhage.

#### EXPERIMENT NO. 19.

Dog was full-grown and apparently healthy. When the abdomen was exposed by shaving, two small abscesses, each the size of a filbert, superficially seated and non-inflammatory, were discovered. They were not disturbed. The animal was anæsthetized at 8:30 A. M., and at once shot through the middle of abdomen with a 44 calibre revolver. The dog was placed upon the table, and a linear incision of about three inches made in the median line. It was there found that the ball had glanced upon the abdominal muscles, and instead of going through the mass of small intestines, had been deflected so that it just entered the peritoneal cavity beneath the linea alba, traversed the cavity for about an inch, producing a contused wound of a fold of intestines, and then entered the abdominal parietes to make its exit opposite the wound of entrance, about two inches from the linea alba. Only a small amount of blood was found in cavity. Although none of the intestines were wounded, a resection of about two inches from the middle of the ileum was made. The divided ends were united by about a dozen interrupted silk sutures. The cavity was washed thoroughly with a 1 per cent. sol. of carbolic acid, the intestines returned, and stitches were being placed in external wound, when the abdominal cavity was found to be filling with blood. Source of the hæmorrhage was found to be a branch of mesen-

teric artery at the site of the resection, which had commenced to bleed as soon as circulation was restored by warmth of abdomen. A ligature was applied, the intestine returned and the cavity again thoroughly washed out. The external wound was now closed by silk sutures, the wound dusted with iodoform, and dressed by applying a few thicknesses of carb. gauze, covering this with a mass of tow and a bandage over all. Animal appeared to suffer but little from shock. On morning of second day was given  $\frac{1}{4}$  grain morphia with 1-100th grain atropia by the mouth.

On the third day appeared greatly prostrated, vomited at intervals, and a muco-purulent discharge was noticed coming from nostrils and eyes. Vomiting ceased on fourth day. Prostration and evidence of fever kept up to the morning of fifth day, when improvement began. Discharge from nostrils continued about ten days. On the fourth day a small quantity of milk was taken and retained. Loose discharge from bowels on fifth day slightly colored with blood. A rectal injection of alcohol; water was given on the sixth day. Dressings changed for the first time on sixth day. Wound appeared healthy and united in its deeper portions. Some pus from superficial part of wound from this time on, the dog ate milk regularly, and had regular and normal passages from bowels. On ninth day sutures were removed from external wound, which had entirely closed. On the thirteenth day, February 10, 1884, dog is apparently perfectly well; has been eating regularly of raw beef, and has begun to gain in flesh. On the evening of thirteenth day dog was well. Recovery.

#### EXPERIMENT NO. 20.

February 2.—(Ball cal. 32.) Died from ether before any incision was made.

#### EXPERIMENT NO. 21.

A strong black dog, about 20 lbs., was shaved over the ab-

domen and then etherized at 9.15 A. M. Was shot with a 38-100 calibre revolver through the abdomen about opposite the umbilicus, and five inches to the right of the median line, the point of exit being in a corresponding situation on the opposite side. Upon opening the abdominal cavity such a large amount of blood was found that it was necessary to enlarge the incision by a cross cut. A large mesenteric artery was found to be cut and was ligated. Another smaller one was treated in the same way. There were two wounds in the small intestine close together, about six inches intervening between them. Extravasation of contents from both. One was perforating and the other nicking the gut on the mesenteric side. Eight inches were removed, and the free extremities of the intestine united by interrupted silk sutures. There were three other wounds nicking the intestine which were sewed in the same manner without resection. The end of the cæcum, which is peculiarly shaped in dogs, was shot off. Stained mucus and some shreds at the opening. This was sewed, turning the cut end in. The spleen was cut in one place, which was left with one deeply-planted suture. A large fold of omentum was ligatured and removed. The abdomen was thoroughly washed with carbolized water, and the external wound united with about fifteen sutures. It was then then dressed with iodoform and oakum,  $\frac{1}{2}$  ounce of alcohol and 15 gtts. of deodorized tincture of opium were administered per rectum, and at 12.15 the dog was allowed to come from the influence of ether. The same amount of alcohol and opium were administered as before at 6 P. M. The dog died during the night. Post-mortem revealed no evidence of inflammation, and some slight bleeding from the spleen. The sutures in the intestine were in good condition. The piece of gut, about eight inches long, supplied by the mesenteric artery, which was cut by the bullet, was found to be completely mortified.

## EXPERIMENT NO. 22.

February 12, 1884.—(Ball cal. 32.) Brindle bull dog. No attempt to sew up the holes in the intestines, of which there were about twenty. Died the day following. "Tilley's anæsthetizer." Every opening showed evidence of extrusion of contents.

## EXPERIMENT NO. 23.

February 28, 1884.—Tilley's anæsthetizer. Died before operation from effects of ether.

## EXPERIMENT NO. 24.

February 28, 1884.—(Ball cal. 44.) A short, strong Spitz dog. Bullet wounds of entrance and exit 4 in. apart. Intestine perforated in four places and abraded in one spot. Intestinal worms free in abdomen. Tape worms protruding from perforations.

Extravasation of contents of the bowel. No arteries divided by bullet. Resected one piece, (including three perforations) 12 in. length. Removed a V-shaped piece including the fourth perforation, and inverted the serous surfaces by interrupted sutures, the same as in complete section. The apex of the V (pointed to the attached border of the bowel) controlled the oozing from the abraded spot by small suture passed across mesenteric side of abrasion, the abrasion being the size of a copper cent, and on the side of intestine. Washed the intestines and abdomen cavity as clean as possible by stream of weak carbolized and pretty warm water from the irrigator; closed abdomen wound by five deeply-placed sutures about one-third inch apart; gave hypod. of one-fourth grain of morphia. Shock and little loss of blood. Omentum also removed.

February 29.—In morning seemed very lively and bright; gave some water, which was immediately rejected by stomach. During morning vomited foul-smelling fluid and two large



chunks of meat. About 10 A. M. gave hypod. of one-half grain morphia; in very few minutes he laid down and began to whine as though in pain, and threw up large quantity of offensively-smelling fluid. Died about 3 P. M.

Post-mortem.—Abdomen showed evidence of intestinal extravasation, all organs being bound together by peritoneal inflammation; extravasation of blood beneath peritoneal covering of intestines, and small clots adherent all along the length of ileum. The stumps of ligated mesentery and omentum were black. The seat of the operation showed adhesion of the serous surfaces, and water could be forced through the excised piece which was taken out by a cut six in. to each side of the stitches, without any leaking at seat of operation. The spot of abrasion was swollen and blue, and there had been a little hæmorrhage from it. The intestines generally were contracted, glued together, and pressed into prismoidal and other shapes. Stomach empty.

#### EXPERIMENT NO. 25.

February 28, 1884.—(Ball cal. 44.) "Tasso."

Bullet under skin opposite to point of entrance. Intestine riddled in about four places, for which a complete section 20 in. in length was removed and was nicely adjusted; another hole in the ascending colon was closed on each side by the continuous suture; the tip of the spleen being shot off, to arrest hæmorrhage a ligature was passed around proximal side of wound tight enough for that purpose, but yet not enough to cause death of the spleen tissue beyond ligature. The stumps of ligated mesentery being gathered upon a suture, were united to intestine near or about at the seat of the approximation of the divided ends; omentum removed; gave rectal injection of alcohol and water  $\frac{1}{2}$   $\frac{1}{2}$  about. Each opening in bowel had more or less of the contents around it.

February 29.—Seemed very quiet all the morning, and was quite indisposed to move. Towards noon, gave him, about 11 o'clock, about 1 oz. of alcohol and water  $\frac{1}{2}$   $\frac{1}{2}$  per rectum and some water to drink, which was at once vomited. Seemed very tired all day and disposed to lie stretched out before the heat of the register, and his breathing was entirely thoracic and by means of the cervical muscles. At 6 P. M. gave hypod. of morph. gr.  $\frac{3}{8}$ , and left water where he could drink.

March 1.—Seemed very weak all day; gave hypod. of morph.  $\frac{1}{2}$  gr. twice, the last at night. About noon gave rectal injection of alcohol and water.

March 2.—Still alive, but very cold; listless and indifferent; gave morph. in A. M., and tied him up in blanket. Returned at nine P. M., and poor "Tasso" was in rigor mortis. I think the exposure to cold during the day (Sunday) which was a very wintry day, was in great measure the cause of his death. He refused to drink any milk during the day, and also seemed to have lost his thirst for water.

Post-mortem March 4.—Extensive peritonitis present; no separation of the united intestine to be found at the seat of operation.

#### EXPERIMENT NO. 26.

March 3.—(44 cal. cartridge.) Large, fat and old bitch. Used Frank Gould's revolver, 44, and upon opening the abdomen, found four large rents in the intestines (every one of which showed extrusion of contents and some worms) at a considerable distance apart, and a very profuse hæmorrhage from the wound of exit, which was not discovered until the resections were made, of which two included the wounds in the gut, which was about shot off, and much bleeding took place before they were found and ligated. The animal was so fat and boggy that it was with the greatest difficulty that

hæmorrhage could be controlled, and the beast was old and presented signs of cataract in both eyes. The bladder was greatly distended, and the structure of the intestines themselves seemed "sleazy," and the sutures tore out with readiness upon slight traction. Cleansed out abdomen as best we could by thorough washing, but a little bleeding was going on when the wound was closed in the abdomen, and the operation given up as a bad job of one-half hour's duration.

March 4.—Found dead.

#### EXPERIMENT NO. 27.

March 4.—(44 cartridge.) Medium-sized dog; died from shock on night of 4th.

#### EXPERIMENT NO. 28.

March 6.—(Ball cal. 22, revolver.) Very small, black and tan dog. Shot him with a 22 cartridge, and had to use three shots before could get a good perforation and but little bleeding. Resected a piece around the bullet-hole of  $\frac{3}{4}$  inches long, cleaned abdomen and closed tightly; gave morph. gr.  $\frac{1}{4}$ .

March 7.—Seemed very bright.

March 8.—Gave little milk and morphia in evening.

March 10.—Milk.

March 11.—Sent down cellar to be fed on milk.

March 12, 13.—Very hearty, and eats ravenously of milk and very little meat.

March 14, 15.—Doing nicely. Recovery.

#### EXPERIMENT NO. 29.

March 6.—(Ball cal. 44.) Large, strong dog. Used 44 cartridge. Found the abdomen full of blood; spleen perforated, and intestines wounded in three or four places. From these issued fæces, gas, etc. Removed spleen, omentum, and resected about 12 in. gut, including all the holes but one, which was sewed up by continuous stitch. The animal having

lost nearly all his blood by this time, and as death was sure to ensue, one of the mesenteric arteries was ligated to ascertain results.

March 7.—Found dead in morning.

Post-mortem.—Intestine black, but the animal had evidently not lived long enough to get any positive mortification of ligatured part, or any interesting appearance at all.

#### EXPERIMENT NO. 30.

March 10.—Tilley's Inhaler. Large chandler bitch. Killed by ether.

#### EXPERIMENT NO. 31.

March 10.—Tilley's Inhaler. Large Hastman dog. Killed by ether.

#### EXPERIMENT NO. 32.

March 10.—(Ball cal. 22, rifle.) Medium-sized bitch. Found three mesenteric arteries severed, and intestines riddled in many places and far apart. Perforations showed fæcal matter and tapeworms. Stopped bleeding and returned intestines without closing the perforations, and closed abdomen. No dressing but iodoform (C. T. P.) Spleen also removed, being perforated.

March 11.—Still alive, and sent down cellar.

March 13, A. M.—No better.

March 14, 15, A. M.—Vomiting, and refused food.

March 18.—Dead. Peritonitis septic. Pockets of fæces.

#### EXPERIMENT NO. 33.

March 10.—Small dog (yellow). Shot with 22 cal. rifle. Three perforations of small intestine, showing fæcal matter. Removed a 4-in. piece in two places, and brought ends together very closely; stitched mesenteric stumps to attached border of intestine. Removed omentum, tying tightly, and also putting in three side stitches connecting sides of stumps on each side of ligation with one another.



March 11.—Alive, but feverish and vomiting.

March 12.— Died. Separation at seat of operation, and stumps mortified. See specimen. Fæcal extravasation.

EXPERIMENT No. 34.

March 12.—(Ball cal. 22 rifle.) Old, mangy bitch. Died under ether. Tilley's Inhaler. Perforation showed extravasation of contents, fæcal matter and worms.

EXPERIMENT No. 35.

March 12.—Medium-sized, short-haired, yellow cur (white nose). Shot with 22-ball rifle. Upon opening the abdomen, found blood flowing from a rent in the side of spleen. This organ was three times the normal size, but no holes in the intestines anywhere, and no hole could be found in the abdominal wall on either side. The bullet lay next the abdominal muscles, and was cut out from the wound of entrance. Free bleeding from the laceration in the spleen, which was controlled by a continued suture. Resected six inches of intestine and closed abdomen. Also omentum removed. Iodoform and oakum dressing; gave morphia.

March 13.— $\frac{1}{4}$  gr. morph. A. M.; very weak P. M.

March 14.—Morph. A. M.; very weak P. M. Temperature 102.

March 15.—Re-opened, but found intestine in solid mass and filled with badly-smelling fluid. Washed out as best I could and reclosed. Seat of operation showed mortification on one side, and stumps mesentery also were black and soft.

March 16.—Still alive. Morph. gr.  $\frac{1}{4}$ .

March 19.—Dead. Found intestinal worms in abdominal cavity.

EXPERIMENT No. 36.

March 12.—Short, black, stumpy and very fat dog. Fired four 22-balls at the animal before was sure that any had entered.

Found abdomen full of blood; two perforations five inches apart, and two mesenteric arteries shot off near the gut. Each perforation showed extravasation, fæces and worms. Ligated the arteries; resected one piece, including both holes; sponged out abdominal cavity; removed omentum, also a large quantity of fat which hung to the inner wall of the belly, and closed wound. Iodoform and oakum dressing; gave morphia.

March 13.—Quite bright. Morph. A. M. and P. M.

March 14.—Dead. Post-mortem. Found considerable peritonitis and mortification of the ends of the intestines where they were stitched together. The stumps of mesentery and omentum also showed signs of mortification.

#### EXPERIMENT NO. 37.

March 13.—Medium-sized brindle bitch. No. 22-ball rifle. Resected one piece six inches having two holes; removed omentum very little; hæmorrhage; gas and fæces from wounds; temperature 98 2-5 at close of operation.

March 14.— $\frac{1}{4}$  gr. morph. A. M. Temperature 102 2-5. Morph. P. M.

March 15.— $\frac{1}{4}$  gr. morph. P. M.; temperature 102 2-5.

March 16.—Morph. P. M.; temperature 102.

March 17.—Gave milk and morph. P. M.

March 19, 20.—Gave milk and morph. P. M.; seems well.

April 22.—Perfectly well; recovery.

#### EXPERIMENT NO. 38.

March 13.—Medium-sized yellow dog (with bare spot on tail). No. 22-ball rifle; found one lateral hole which closed by continuous suture, and three holes which were included in one piece which was cut in half by mistake; two arteries gave some bleeding, but were ultimately controlled. Contents of bowel found at each wound. Abdomen closed while yet there was

some oozing from the wound, which ceased when bandages were applied; omentum removed.

March 14.—Very weak and much prostrated. Refused to lie down, and can stand with difficulty on his feet. Gave morphia  $\frac{3}{8}$  hypodermically, morning and evening.

March 15.—Found dead. Post-mortem. Mortification at seat of operation, and escape of intestinal contents.

#### EXPERIMENT No. 39.

March 14.—(Ball 22-cal. rifle.) Medium-sized brindle dog (wolf face); found three ragged holes. Resected one piece which included all openings, the piece being seven inches long; closed neatly, the omentum being removed also (many tapeworms and considerable faecal matter from openings), then washed clean by irrigator. The entire ileum was inspected and sponged off, and returned to abdomen. Spleen also pulled out and inspected; gave morphia and dressings of iodoform and oakum.

March 15.—Some shock; morphia.

March 16.—Morphia P. M. only.

March 17.—Morphia P. M. only.

March 19.—A. M. morphia, stercoraceous vomiting, and seems very sick; P. M. is evidently dying.

March 20.—Vomiting has stopped, and seems much better. Died in the evening. P. M. Septic peritonitis. Post-paritoneal abscesses.

#### EXPERIMENT No. 40.

March 14, 4.45 P. M.—A young, black, bitch pup; anæsthetized and abdomen opened without shooting; ligated a mesenteric artery and closed wound to be re-opened to-morrow P. M. and resect the part supplied by ligated vessel; gave morph.  $\frac{3}{8}$ .

March 15.—Opened her at 3 P. M. in presence of Prof. Parkes. Intestine supplied by the ligated artery seemed softer than

normal and its mesentery showed inflammatory exudate considerable effusion; closed wound, gave morphia at night.

March 16.—Gave morphia, gr.  $\frac{1}{4}$ .

March 17.—Sent down stairs.

March 19.—Seems quite well.

April 22.—Perfectly well. Recovery.

#### EXPERIMENT NO. 41.

March 19.—(Ball 22-cal. rifle.) Medium-sized young bitch (black). Found one abrasion which closed up by continued suture and the intestine in another place was about shot off; faecal matter scattered all about, worms divided; resected the piece about one inch long; irrigated the abdomen cavity; removed omentum and then found a hole or rather the tip of the spleen shot off which bled some and was controlled by two interrupted sutures; gave morphia, gr.  $\frac{1}{4}$ , and applied dressings.

March 18, 19.—Morphia, gr.  $\frac{1}{2}$ .

March 20.—Seems bright, but very quiet.

April 22.—Quite well. Recovery.

#### EXPERIMENT NO. 42.

March 19.—Twenty-two ball rifle (brindle, white bitch). Found one abraded edge and one hole through free edge of ileum, from which contents issued. Closed one by continued suture and resected across the hole by cutting out a  $\frac{3}{4}$  inch piece. Did not remove omentum. Gave morphia  $\frac{3}{8}$  and applied dressing.

March 18 and 19.—Morphia. Seems to have a paralysis of left fore-leg since operation and for two days past seems to be salivated.

March 20.—Better.

April 22.—Well. Recovery.



## EXPERIMENT NO. 43.

March 20.—(Stub tail.) A small half-breed terrier dog. Twenty-two ball rifle. Found two perforations and one abrasion, extravasation of gas and stained mucus and shreds of matter from openings going through mucous coat. Made a resection including all three wounds, the excised piece being six inches long, closed very snugly and connected the ligated mesenteric stumps with the attached border of intestine by a single ligature passing through both stumps (but two sets of vessels having been ligated) and both sides of the mesenteric borders of the united ends of the gut; removed omentum and irrigated abdomen cavity freely with a 1 per cent. of carbolic acid solution. Dressings, oakum and iodoform; gave morphia,  $\frac{1}{4}$ . Recovery.

## EXPERIMENT NO. 44.

March 20.—A young, shaggy, cur dog opened without shooting, and ligated three sets of branches from the superficial mesentery artery, close to the main artery, and also a good-sized anastomatic connection with an adjoining vasa intestine tenuis, which ran parallel with and along the attached border of the bowel. The intestines supplied by the vessels blanched immediately. Closed abdomen; gave morphia, gr.  $\frac{1}{4}$ ; applied dressings. Recovered.

Died subsequently from ether during examination as to result of above operation six days after it. Found intestine perforated by stick of wood four inches long, rolled in twine. Had removed it, and was about to sew up wound when ether killed him.

## EXPERIMENT NO. 45.

March 20.—A good-sized spaniel dog (old). Stopped breathing once from ether before shooting. Shot with a rifle twenty-two ball. Found the abdomen full of blood, two arteries hav-

ing been shot off and the ileum perforated in four places; from each contents extruded, two being so near together and the wounds so great as to almost carry away an entire segment of the bowel, necessitating a removal of about twenty inches. Much bleeding, which took about half-an-hour to control, being from the ligated stumps and bullet-wounds; the tissues were very brittle, and so loaded with fat as to make the operation difficult. Died in one half-hour after closing abdomen wound. •

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#### PATHOLOGICAL SPECIMENS SHOWN.

1st. Section of ileum made 24 hours after operation; showing the sutures all covered with exudate. Union sufficiently firm to allow distention with water without leaking.

2nd. Sections of intestines made four, six and eight weeks after operation—the animal having fully recovered. The union is firm and solid throughout entire circumference of the bowel. No narrowing of tube, or disposition to formation of a stricture. Two of the specimens show several of the sutures ulcerating into the lumen of the bowel.

3rd. Several specimens showing mortification of distal ends of stumps, and also mortification of applied edges of the bowel from tight sutures and ligatures.

4th. Several specimens showing giving way of sutured bowel ends at the mesenteric junction, allowing extravasation causing fatal inflammation—sutures failed to include the muscular coat.

5th. Specimens showing many varieties of wounds produced by the bullet.

















